

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32001

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Angela Montiel

2. Date of Death

Month Day Year
SEPT. 28, 2000

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

1109 PARRISH DR.

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

219-21-0318

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
11-29-04

9. Birthplace (State or Foreign Country)

NICARAGUA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1109 Parrish Drive

10f. Zip Code

20852

10g. Citizen of What Country?

NICARAGUA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify:
NICARAGUAN14. Race - American Indian,
Black, White, etc.Specify:
WHITE15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

DIONISIO

MONTIEL

18. Mother's Name (First, Middle, Maiden Surname)

EMILIA

GOMEZ

19a. Informant's Name/Relationship (Type, Print)

MAGDA SOBALVARRO/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

9/30/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

M. W. Chambers

MO0091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. Congestive Heart Failure
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Coronary Artery Disease
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Galen Hallick M.D.

29c. License number

D 28426

29d. Date signed (Month, Day, Year)

Sept. 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Galen Hallick M.D. 11125 Rockville Pike, Rockville, Md 20852

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 20 1954

RECEIVED

NOV 20 1954

RECEIVED

NOV 20 1954

NOV 20 1954

RECEIVED

NOV 20 1954

RECEIVED

NOV 20 1954

RECEIVED

NOV 20 1954

RECEIVED

NOV 20 1954

RECEIVED

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32002

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Louise Mobley				2. Date of Death Month September Day 21 Year 2000				3. Time of Death 3:21 AM		
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 412-34-7480		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) January 30, 1927		9. Birthplace (State or Foreign Country) Tennessee		
	10a. State Maryland				10b. County Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 2304 Veirs Mill Road				10f. Zip Code 20851				10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) - College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Draftsperson				16b. Kind of Business/Industry Vitro Corporation			
17. Father's Name (First, Middle, Last) David E. Hurst				18. Mother's Name (First, Middle, Maiden Surname) Marie Wilshire							
19a. Informant's Name/Relationship (Type, Print) Thomas E. Conkey/ Son in law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9122 Keyser Road, Nokesville, Virginia 20181							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date September 22, 2000		20c. Location - City or Town, State Bethesda, Maryland			
21. Signature of Funeral Service Licensee  880689				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death Hours			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number 27330				29d. Date signed (Month, Day, Year) 9.21.00			
29b. Signature and title of partner  LISTELLO											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank Listello, M.D., 9901 Medical Center Drive, Rockville, MD 20850											
31. Date filed (Month, Day, Year) SEP 25 2000				32. Registrar's Signature 							

11/11/11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32003

Amend #8, 10/6/2000, BMW, Montg. Co

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eleanor Pittman Mitchell				2. Date of Death Month Day Year Sept. 21, 2000		3. Time of Death 8:30 p.m.	
	4a. Facility Name (If not institution, give street and number) Bedford Court				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-32-6769		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 12, 1902	
	9. Birthplace (State or Foreign Country) WV							
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3700 International Drive				10f. Zip Code 20906		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Joseph Jay Pittman				18. Mother's Name (First, Middle, Maiden Surname) Lulu Frye			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Jay Robinson /nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Marine Terrace Silver Spring, MD 20905			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 9/23/00 Alexandria, VA			
	21. Signature of Funeral Service Licensee Chris Adams				22. Name and Address of Facility Adams-Green Funeral Home 721 Elden Street Herndon, VA			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Broncopneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death days							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Accident Hypertension						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier James H. Adams		29c. License number D33357		29d. Date signed (Month, Day, Year) 9/22/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lee Jonathan Musher was 5530 Wisconsin Ave Chevy Chase MD 20815								
31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature James B. Sparks						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32004

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret K. McVicker

2. Date of Death

Month 09 Day 20 Year 2000

3. Time of Death

3:10 AM

4a. Facility Name (If not institution, give street and number)

Solomon Nursing Center

4b. City, Town, or Location of Death

Dowell

4c. County of Death

Calvert

Funeral
Director

5. Social Security Number

230-46-1773

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02-01-14

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Solomons

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 1263

10f. Zip Code

20688

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Caucasian

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Agent

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Wilbur D. Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Lenore C. Englehardt

19a. Informant's Name/Relationship (Type, Print)

Ann Michnowicz / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1263, 255 C Street, Solomons, MD 20688

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Memorial Park

Date

9/26/00

20c. Location - City or Town, State

Fairfax Co., Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Murphy Falls Church Funeral Home

1102 West Broad Street Falls Church, VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Barth, MD

P.O. Box 1428, Solomons, Maryland 20688

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32005

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth A. McKay

2. Date of Death

September 21, 2000 12:00 pm

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

17408 Blossom View Drive

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

577-01-0804

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 28, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2010 Arcola Avenue

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

James Maurice Phillips

18. Mother's Name (First, Middle, Maiden Surname)

Virgie Ellen Clark

19a. Informant's Name/Relationship (Type, Print)

James L. McKay / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

224 Nichols Manor Drive, Stevensville, MD 21666

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/26/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Metastatic Transitional Cell Carcinoma

Approximate
Interval Between
Onset and Death

2 years

Due to (or as a consequence of):

b. Invasive Bladder Cancer

5 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bone Metastases

Recurrent Urinary tract infections

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)Daughter's
Residence

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Linda M. Burrell, MD

29c. License number

D 35996

29d. Date signed (Month, Day, Year)

September 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, MD 2730 University Blvd., West# 400, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Sandra B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32006

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

FRANCES R. McHUGH

2. Date of Death

Month Day Year
September 23, 2000

3. Time of Death

10:25 pm

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-76-0416

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 27, 1915

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9105 Hunting Horn Lane

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Frederick Lanman

18. Mother's Name (First, Middle, Maiden Surname)

Mary F. Keeler

19a. Informant's Name/Relationship (Type, Print)

Dennis M. McHugh/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4701 Rams Head Court, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/27/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Anchew Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Respiratory failure
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Pneumonia
Due to (or as a consequence of):c. S/P (L) AORTORENAL BYPASS
Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Louis Kozloff

29c. License number

D23019

29d. Date signed (Month, Day, Year)

9/24/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOUIS KOZLOFF, MD 8218 WISCONSIN AVE; BETHESDA, MD 20814

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23d show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

12

1947-1948

Redwood Forest

Forest

1/2 (1/2) (1/2) (1/2)

Forest

Forest

X

X

X

X

X

1947-1948

1947-1948

1947-1948

1947-1948

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32007

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Patrick McGivern				2. Date of Death Month Day Year September 24, 2000		3. Time of Death 9:45pm	
	4a. Facility Name (If not institution, give street and number) 1744 Point No Point Dr.				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 097-05-8950	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 1, 1911	9. Birthplace (State or Foreign Country) NY	
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. Street and Number 1744 Point No Point Dr.				10f. Zip Code 21401		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive		16b. Kind of Business/Industry Communications		
17. Father's Name (First, Middle, Last) John Aurthor McGivern				18. Mother's Name (First, Middle, Maiden Surname) Rose Abruscate				
19a. Informant's Name/Relationship (Type, Print) Berta McGivern /Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1744 Point No Point Dr., Annapolis, MD 21401				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Sep 27 2000		20c. Location - City or Town, State Beltsville, MD		
21. Signature of Funeral Service Licensee Beverly L. Halseth				22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>myelodysplastic syndrome</u> Due to (or as a consequence of): b. <u>myocardial infarction</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dickites</u>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Victor Plavner				29c. License number D28686		29d. Date signed (Month, Day, Year) 9/26/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Victor Plavner MD 1509 Ritchie Hwy Arnold, MD 21012								
31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature B. Spauls				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32008

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Teresa Agnes McCleary		2. Date of Death Month Day Year September 27, 2000		3. Time of Death 12:27 pm	
	4a. Facility Name (If not institution, give street and number) Holy Cross Rehabilitation and Nursing Center		4b. City, Town, or Location of Death Burtonsville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 164-03-8640	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 6, 1910
	9. Birthplace (State or Foreign Country) England					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Burtonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3305 Bigelow Court		10f. Zip Code 20866		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) John Patrick Davitt		18. Mother's Name (First, Middle, Maiden Surname) Julia Christiana Ormsby			
	19a. Informant's Name/Relationship (Type, Print) Robert T. McCleary / Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Bigelow Court, Burtonsville, MD 20866			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State 9/30/00 Silver Spring, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901			
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Squamous Cell Carcinoma of Mouth					2 years
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
	Due to (or as a consequence of):					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
	Hypertension					
	Hyperlipidemia					
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number D 37975		29d. Date signed (Month, Day, Year) September 28, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffery Indrisano, MD 10801 Lockwood Drive, #280, Silver Spring, MD						
State Registrar	31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32009

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret M. McCarthy

2. Date of Death

September 22, 2000

3. Time of Death

11:05 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

097-10-7593

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 1, 1917

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 Gruenther Court

10f. Zip Code

20851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John M. Murphy

18. Mother's Name (First, Middle, Maiden Surname)

Mary Katherine McLoone

19a. Informant's Name/Relationship (Type, Print)

Charles G. McCarthy / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Gruenther Court, Rockville, MD 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/26/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

William L. Byn

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Artherosclerotic Heart Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jonathan Musher

29c. License number

D33357

29d. Date signed (Month, Day, Year)

9/23/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lee Jonathan Musher 5530 Wisconsin Ave Chevy Chase

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32010

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Nina Maria Marriott				2. Date of Death Month Day Year Sept. 22, 2000				3. Time of Death 6:18 PM			
4a. Facility Name (If not Institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery			
5. Social Security Number 098-34-4656		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) June 16, 1945		9. Birthplace (State or Foreign Country) New York			
Usual Residence of Decedent											
10a. State none		10b. County none		10c. City, Town or Location Washington, D.C.				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 4545 MacArthur Blvd., N.W. #107				10f. Zip Code 20007				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Businesswoman				16b. Kind of Business/Industry Restaurateur			
17. Father's Name (First, Middle, Last) Jules Jacobs						18. Mother's Name (First, Middle, Maiden Summa) Margo Harrow					
19a. Informant's Name/Relationship (Type, Print) Anjulie M. Marriott/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4545 MacArthur Blvd., NW, #107, Wash., D.C. 20007							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Gardens		Date Sept. 27, 2000		20c. Location - City or Town, State Arlington, Virginia			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardio-Pulmonary Arrest Due to (or as a consequence of): b. Advanced Multiple Sclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fa: Lure to Thrive											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D0030111		29d. Date signed (Month, Day, Year) September 23, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary W Jones MD PO Box 385 Laurel Md 20725-0385											
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.


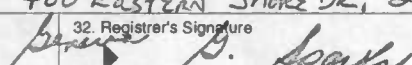
[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32011

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALFRED WOODS MICHAEL				2. Date of Death Month September Day 16 Year 2000		3. Time of Death 0709
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 109-03-4936	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 2-12-15	9. Birthplace (State or Foreign Country) NEW YORK
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County WICOMICO	10c. City, Town or Location HEBRON			10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number: 7399-CHERRY WALK ROAD			10f. Zip Code 21830		10g. Citizen of What Country? USA	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ARMY If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11-5 College (1-4 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POSTAL WORKER		16b. Kind of Business/Industry N.Y. POSTAL SERVICE		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) CHARLES F. MICHAEL			18. Mother's Name (First, Middle, Maiden Surname) ELIZERA YEARWOOD MICHAEL			
	19a. Informant's Name/Relationship (Type, Print) CYNTHIA MICHAEL - WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7399-CHERRY WALK RD. HEBRON, MD. 21830			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARTIN LUTHER KING MEM. GARDEN 9/21/2000 BALTIMORE, MD.		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility BENNIE SMITH F/H 917 W ISABELLA ST. SALISBURY, MD. 21801				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Ventricular Fibrillation Due to (or as a consequence of) b. Cardiomyopathy Due to (or as a consequence of) c. Due to (or as a consequence of) d.						Approximate Interval Between Onset and Death
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	25. Was case referred to medical examiner? 1 Yes 2 No						26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) 9/16/00		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
	28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier Benjamin H Meyer			29c. License number D30743		29d. Date signed (Month, Day, Year) 9/16/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Meyer 400 Eastern Shore Dr, Salisbury, Md, 21804						
	31. Date filed (Month, Day, Year) SEP 19 2000			32. Registrar's Signature 			

412

1968

10/12/68

Dear Mr. [illegible]

Very truly yours,

[illegible signature]

[illegible text]

[illegible text]

[illegible signature]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32012

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY E. McDEVITT

2. Date of Death
Month Day Year
SEPT. 20 20003. Time of Death
6:05 PM

4a. Facility Name (If not institution, give street and number)

WATERVIEW HEALTHCARE CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

204-38-9302

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JUNE 30, 1913

9. Birthplace (State or Foreign Country)

PENNSYLVANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

105 TIMES SQUARE

10f. Zip Code

21803

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

JOHN ESCHBACH

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH ALEXANDER

19a. Informant's Name/Relationship (Type, Print)

KATHY NACRELLI - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1000 SCHUMAKER WOODS RD SALISBURY, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SS PETER & PAUL CEMETERY 09/25/00 SPRINGFIELD, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

705 E. MAIN ST.

BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

CHF

Due to (or as a consequence of):

ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47094

29d. Date signed (Month, Day, Year)

9/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NATEJAN, V. MD 106 MILFORD STREET SALISBURY MD 21804

31. Date filed (Month, Day, Year)

SEP 22 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Amended #16a, NDL,
9/25/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32013

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Leonard C. Moreland

2. Date of Death
Month Day Year

September 25, 2000 5:20 A.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

236-36-1524

6. Sex

X ☐ M ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min

8. Date of Birth

Sep 1, 1926

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

WV

10b. County

Mineral

10c. City, Town or Location

Ridgeley

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Route 2 Box 258

10f. Zip Code

26753

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

☐ Yes ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

retired pipefitter

16b. Kind of Business/Industry

Contracting

17. Father's Name (First, Middle, Last)

Benjamin Cleveland Moreland

18. Mother's Name (First, Middle, Maiden Surname)

Anna P Culp

19a. Informant's Name/Relationship (Type, Print)

Leona Moreland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Route 2 Box 258; Ridgeley WV 26753

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Ashby Cemetery

Date

9/27/

2000

20c. Location - City or Town, State

Fort Ashby, WV

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility
Scarpelli Funeral Home, P.A.
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one disease on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Bilateral pneumonia
Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

3 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy
performed?

☐ Yes ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☐ Yes ☒ No

25. Was case referred to medical
examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

28c. Injury et
Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael Zang

29c. License number

D0054426

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Michael Zang, Memorial Hospital Medical Building, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Benjamin B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LEONARD MORELAND 236-36-1524

Division of Vital Records, P.O. Box 68760,

no original copy, but in a list

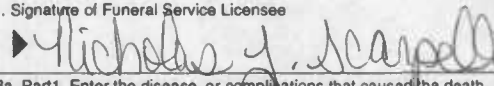
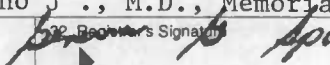
Amended # 26, N.H.S.,
9/19/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32014

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Susan McCarty				2. Date of Death Month Day Year 9-7-2000		3. Time of Death 4:10a.m.						
	4a. Facility Name (If not institution, give street and number) Memorial Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany						
Funeral Director	5. Social Security Number 217-14-4005		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth Month Day Year Aug 15, 1921	9. Birthplace (State or Foreign Country) PA					
	Usual Residence of Decedent												
10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
10e. Street and Number 550 Rose Hill Avenue				10f. Zip Code 21502		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white							
15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Former Employee		16b. Kind of Business/Industry Burton's Clothing							
17. Father's Name (First, Middle, Last) John Henry Winterstine				18. Mother's Name (First, Middle, Maiden Surname) Duetta (Combs)									
19a. Informant's Name/Relationship (Type, Print) Dennis McCarty son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12028 Wishing Well Lan; Cumberland MD 21502									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gard		Data 9/08/		20c. Location - City or Town, State LaVale, MD							
21. Signature of Funeral Service Licensee 				22. Name and Address of Funeral Home Scarpelli Funeral Home, P.A. Cumberland, MD 21502									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADENOCARCINOMA, COLON Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 Mos.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 							29c. License number D0014865		29d. Date signed (Month, Day, Year) September 13, 2000		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Barrera, Robustiano J., M.D., Memorial Medical Bldg., Cumberland, Maryland 21502													
31. Date (Month, Day, Year) SEP 19 2000												32. Registrar's Signature 	

James B. Smith

SEP 12 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32015

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward L. Morris, Jr.				2. Date of Death Month Day Year Sept. 14, 2000		3. Time of Death 10:45 AM	
	4a. Facility Name (If not institution, give street and number) 9202 Cropper Island Road				4b. City, Town, or Location of Death Newark		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 465-60-6257		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 6, 1939	
	9. Birthplace (State or Foreign Country) Massachusetts		10e. State MD		10b. County Worcester		10c. City, Town or Location Newark	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9202 Cropper Island Road		10f. Zip Code 21841		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Marines		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction				
17. Father's Name (First, Middle, Last) Edward L. Morris, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Mary Redman				
19a. Informant's Name/Relationship (Type, Print) Jane L. Morris				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9202 Cropper Island Road Newark, Maryland 21841				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 9/16/00 Salisbury, Maryland				
21. Signature of Funeral Service Licensee David H. Thompson MD/051		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Progressive/metastatic prostate cancer sev. years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. L. Morris, Jr. MD Assoc. Prof.						
29c. License number D33759		29d. Date signed (Month, Day, Year) 9/14/00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARIF HUSSEIN 22 S. GREENE ST, BALTIMORE, MD 21201								
31. Date filed (Month, Day, Year) SEP 18 2000		32. Registrar's Signature S. Sparks						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32016

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine B McNamera

2. Date of Death

Month Day Year
October 2, 2000

3. Time of Death

6:00am

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

216 20 3778

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 26, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4921 Eastwood Place

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

George Brunner

18. Mother's Name (First, Middle, Maiden Surname)

Catherine McHugh

19a. Informant's Name/Relationship (Type, Print)

Chris McNamara/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5639 Bartholow Road Sykesville, MD 21784

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Garrison Forest Vet. Cem. 10-6-2000 Owings Mills, MD

21. Signature of Funeral Service Licensee

Shema Collins - obit

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CVA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, AODM, Renal Failure

DM Neuropathy, Chronic Atelectasis

Respiratory Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marshall Freedman

29c. License number

H37211

29d. Date signed (Month, Day, Year)

OCT. 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marshall Freedman, 2 Knoll N. COLUMBIA, Md 21045

31. Date filed (Month, Day, Year)

OCT - 3 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32017

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lillian Elizabeth Miller				2. Date of Death Month Aug Day 31 Year 2000				3. Time of Death 03:15 AM		
	4a. Facility Name (If not institution, give street and number) Moran Manor Nursing Home				4b. City, Town, or Location of Death Westernport				4c. County of Death Allegany		
Funeral Director	5. Social Security Number 213-22-4400		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1915		9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland				10b. County Allegany		10c. City, Town or Location Westernport		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number Rt. 1 Box 13				10f. Zip Code 21562				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bartender				16b. Kind of Business/Industry Club			
17. Father's Name (First, Middle, Last) Stewart Michael						18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Wilkinson					
19a. Informant's Name/Relationship (Type, Print) Barbara Clark						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Miller Road, Barton, MD 21521					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery				Date 09/02/2000		20c. Location - City or Town, State Westernport MD	
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, MD 21562					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 week 1 week	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease Respiratory Failure; Congestive Heart Failure								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number 221244		29d. Date signed (Month, Day, Year) 8/31/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus H. Tan M Frostburg Plaza, Frostburg, MD 21532											
31. Date filed (Month, Day, Year) SEP - 1 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 32018

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Grace Ethel Martin				2. Date of Death Month Day Year Sept. 7, 2000				3. Time of Death 11:25 PM		
	4a. Facility Name (If not Institution, give street and number) Cuppett-Weeks Nursing Home				4b. City, Town, or Location of Death Oakland				4c. County of Death Garrett		
Funeral Director	5. Social Security Number 213-24-6468		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 10, 1908		9. Birthplace (State or Foreign Country) Maryland		
	10e. State MD		10b. County Garrett		10c. City, Town or Location Oakland		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 215 N. Fourth St.		10f. Zip Code 21550		10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aide		16b. Kind of Business/Industry Hospital/Nursing Home		17. Father's Name (First, Middle, Last) Archibald ----- Bowser		18. Mother's Name (First, Middle, Maiden Surname) Elva Rebecca Friend			
19a. Informant's Name/Relationship (Type, Print) Robert B. Alexander/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 N. Fourth St., Oakland, Md. 21550							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens				20c. Date 9/10/00		20d. Location - City or Town, State Oakland, Maryland	
21. Signature of Funeral Service Licensee B. B. Alexander				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 5 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD, diabetes type 2, spinal stenosis, hypothyroidism, osteoporosis, right renal neoplasm										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Margaret A. Kaiser MD				29c. License number D26650		29d. Date signed (Month, Day, Year) 9/8/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margaret A. Kaiser, MD 13079 Garrett Highway, Oakland, MD 21550											
31. Date filed (Month, Day, Year) SEP - 8 2000				32. Registrar's Signature B. B. Alexander							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32019

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAI THI NGUYEN				2. Date of Death Month Day Year SEPT. 25, 2000		3. Time of Death 10:07 PM		
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 217-06-9456		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 19, 1954		
	9. Birthplace (State or Foreign Country) VIETNAM		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 10393 COLUMBIA PIKE #B9		10f. Zip Code 20904		10g. Citizen of What Country? VIETNAM	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: ASIAN			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		College (1-4 or 5+) NEVER WORKED		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NEVER WORKED		16b. Kind of Business/Industry NONE			
17. Father's Name (First, Middle, Last) PHUNG DINH NGUYEN				18. Mother's Name (First, Middle, Maiden Surname) DAC THI VU					
19a. Informant's Name/Relationship (Type, Print) THOA DINH NGUYEN/BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 DUKE ST. #404, ALEXANDRIA, VA. 22304					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY		20c. Date 9/30/00		20d. Location - City or Town, State SILVER SPRING, MD.			
21. Signature of Funeral Service Licensee  MOOO91				22. Name and Address of Facility CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD.				20906	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. METASTATIC SQUAMOUS CELL CARCINOMA OF THE CERVIX Due to (or as a consequence of):						Approximate Interval Between Onset and Death	
		b. Due to (or as a consequence of):							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  RAYMOND M. WHITE MD				29c. License number D43539		29d. Date signed (Month, Day, Year) SEPT. 25, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND M. WHITE, M.D. 1500 FOREST GLEN RD., SILVER SPRING, MD.									
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32020

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH L. NICKENS		2. Date of Death Month SEPT. Day 24, Year 2000		3. Time of Death 4:28 AM
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL		4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 577-38-1223	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct. 26 1930		9. Birthplace (State or Foreign Country) Md.		
Usual Residence of Decedent					
10a. State Md.		10b. County Prince George's		10c. City, Town or Location Hyattsville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 5009 40th Place #T-4			10f. Zip Code 20781		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laundry Worker		16b. Kind of Business/Industry Laundry	
17. Father's Name (First, Middle, Last) Charles Noland			18. Mother's Name (First, Middle, Maiden Surname) Mary Robinson		
19a. Informant's Name/Relationship (Type, Print) Keema Richardson / Granddaughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 40th Pl., #T-4 Hyattsville, Md. 20781		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Mem. Gardens		20c. Location - City or Town, State Clinton, Md.	
21. Signature of Funeral Service Licensee Larry Caffer		22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PULMONARY EDEMA, CARDIARRHYTHMIA Due to (or as a consequence of): b. CORONARY ARTERY DISEASE, HYPERTENSION Due to (or as a consequence of): c. LEFT VENTRICULAR DYSFUNCTION Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (1) DIABETES MELLITUS (2) CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Mohammed A. Mannan MD		29c. License number D24593		29d. Date signed (Month, Day, Year) 9.26.00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED A. MANNAN MD, 3331- TOLEDO TERRACE, HYATTSVILLE, MD. 20782					
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32021

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lena Disparti Nasca

2. Date of Death

September 23, 2000

3. Time of Death

2:55 am

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice-Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

073-09-0017

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 4, 1906

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

15310 Beaverbrook Court

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

American Red Cross

17. Father's Name (First, Middle, Last)

Nicholas Disparti

18. Mother's Name (First, Middle, Maiden Surname)

Fortunata Latona

19a. Informant's Name/Relationship (Type, Print)

Richard J. Nasca, M.D. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1912 Verrazzano Drive Wilmington, North Carolina 28405

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Marys Cemetery

Date

9/26/00 Geneseo, New York

21. Signature of Funeral Service Licensee

Steve D. Standa

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Chronic Heart Failure

Due to (or as a consequence of):

1 yr

b. Atherosclerotic Heart Disease

Due to (or as a consequence of):

15 yrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pleural Effusion

Renal Insufficiency

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. P. Libre

29c. License number

D 09470

29d. Date signed (Month, Day, Year)

September 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre, M.D. 10400 Connecticut Avenue Kensington, Maryland 20895

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Eugene P. Libre

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

50

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32022

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD HENRY NORAIR, SR

2. Date of Death

Month Day Year
Sept 22 2000

3. Time of Death

0400

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

578-36-7274

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
APRIL 8, 1929

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

27825 CEDAR POINT RD

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: WHITE15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

CONTRACTOR/DEVELOPER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

HRANDT NORAIR

18. Mother's Name (First, Middle, Maiden Surname)

ANNE SPEIKER

19a. Informant's Name/Relationship (Type, Print)

ALICE B. NORAIR/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27825 CEDAR POINT RD EASTON, MD 21601

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

CHESAPEAKE CREMATION CTR 9-28-2000 STEVENSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENEBIN & NEWMAN FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Mesothelioma*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D31887

29d. Date signed (Month, Day, Year)

9/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID H. SMITH M.D. 29466 PINTAIL DR STE 5 EASTON, MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Richard Norair

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32023

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED NIBBLETT		2. Date of Death Month Day Year September 20 2000		3. Time of Death 12:05 p. m.	
	4a. Facility Name (If not institution, give street and number) Wilcomico Nursing Home		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 446-20-4406	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 9, 1921
	9. Birthplace (State or Foreign Country) Oklahoma					
Usual Residence of Decedent						
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 1502 Arbutus Drive			10f. Zip Code 21804		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Restaurant	
17. Father's Name (First, Middle, Last) William B. Winningham			18. Mother's Name (First, Middle, Maiden Surname) Annie Warren			
19a. Informant's Name/Relationship (Type, Print) Sam Nibblett/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1502 Arbutus Dr., Salisbury, MD 21804			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		Date 9/25/00		20c. Location - City or Town, State Hebron, MD
21. Signature of Funeral Service Licensee Keith R. Downey			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Advanced Multi-Infarct Dementia 10 yrs Due to (or as a consequence of): b. Multiple CVA, Cerebral Infarcts 10 yrs Due to (or as a consequence of): c. Arteriosclerotic Cerebrovascular Disease 12 yrs Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Essential Hypertension Hypertensive Cardiovascular Disease Coronary Artery Disease. Anemia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Gregorio M. Belloso M.D.			29c. License number D 29505		29d. Date signed (Month, Day, Year) 9-20-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregorio Belloso 5302 Chinaberry Drive Salisbury MD 21801						
31. Date filed (Month, Day, Year) SEP 22 2000		32. Registrar's Signature James B. Sparks				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32024

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sade Owens</i>		2. Date of Death Month <i>September</i> Day <i>22</i> Year <i>2000</i>		3. Time of Death <i>19:15 pm</i>
	4a. Facility Name (If not institution, give street and number) <i>The Johns Hopkins Hospital</i>		4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death
Funeral Director	5. Social Security Number <i>216-27-1367</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>14</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>OCT. 5, 1985</i>		9. Birthplace (State or Foreign Country) <i>WASHINGTON, DC</i>		
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>P.G.</i>		10c. City, Town or Location <i>OXON HILL</i>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <i>1307 DUNWOODY AVENUE</i>		10f. Zip Code <i>20745</i>		10g. Citizen of What Country? <i>USA</i>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10TH</i> College (1-4 or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>STUDENT</i>		16b. Kind of Business/Industry <i>N/A</i>
	17. Father's Name (First, Middle, Last) <i>DAVID HARTUNG</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>TOWANA M. OWENS</i>		
	19a. Informant's Name/Relationship (Type, Print) (MOTHER) <i>TOWANA M. OWENS-LAWRENCE</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1307 DUNWOODY AVE, OXON HILL, MD. 20745</i>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>METROPOLITAN CREMATORY</i>		20c. Location - City or Town, State <i>9/28/00 ALEX, VA.</i>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, DC. 20011</i>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cerebral Edema</i> Due to (or as a consequence of): <i>Anoxia, Hypoxia And Ischemia</i> Due to (or as a consequence of): <i>Cardiac Arrest After Endotracheal Intubation</i> Due to (or as a consequence of): <i>Severe Heart Failure, Severe Aortic Stenosis</i>				Approximate Interval Between Onset and Death <i>3 Days</i> <i>3 Days</i> <i>3 Days</i> <i>Months</i>
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <i>Josephine Lok MD</i>		29c. License number <i>RES-000</i>		29d. Date signed (Month, Day, Year) <i>September 25, 2000</i>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Josephine Lok 600 North Wolfe Street Baltimore, Maryland 21287</i>				
	31. Date filed (Month, Day, Year) <i>SEP 28 2000</i>		32. Registrar's Signature <i>[Signature]</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32025

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roderick John O'Neil				2. Date of Death Month Day Year September 22, 2000		3. Time of Death 11:35PM	
	4a. Facility Name (If not institution, give street and number) 1677 Pleasant Plains Road				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 263-60-3644		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Oct 30, 1930	
	9. Birthplace (State or Foreign Country) Florida		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1677 Pleasant Plains Road		10f. Zip Code 21401		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 53-57		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Consultant		16b. Kind of Business/Industry Self-employed		17. Father's Name (First, Middle, Last) Thomas Francis O'Neil	
	18. Mother's Name (First, Middle, Maiden Surname) Mary Pearl Agnew		19a. Informant's Name/Relationship (Type, Print) Roderick O'Neil /Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1677 Pleasant Plains Rd, Annapolis, MD 21401		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Sep 27 2000		20c. Location - City or Town, State Beltsville, MD		21. Signature of Funeral Service Licensee Beverly L. Helt	
	22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Head and Neck Cancer Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 21months		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Russell R. DeLuca		29c. License number D31551		29d. Date signed (Month, Day, Year) September 26, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell R. DeLuca, MD 1600 S. Craig Highway, Hyattsville, MD 21061		31. Data filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature B. Sparks		33. State Registrar	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32026

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW THOMAS OLCESE

2. Date of Death

Month Day Year
Sept 24 2000

3. Time of Death

9:05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

186-10-2063

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Nov. 9, 1919

9. Birthplace (State or Foreign Country)

Penna.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Talbot

10c. City, Town or Location

St. Michaels

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

915 Riverview Terrace

10f. Zip Code

21663

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give

Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

15a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Fencing Contractor

17. Father's Name (First, Middle, Last)

Augustus Olcese

18. Mother's Name (First, Middle, Maiden Surname)

Edith Constantine

19a. Informant's Name/Relationship (Type, Print)

Mary Ellen Olcese Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7132 Pea Neck Rd. St. Michaels, Maryland 21663

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Capitol Crematory Sept. 25, 2000 Dover, Delaware

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harrison E. Leonard

22. Name and Address of Facility

Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Maryland 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage dementia -
Due to (or as a consequence of)

Approximate Interval Between Onset and Death

5 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

HTN

Depression -

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harrison E. Leonard

29c. License number

H42587

29d. Date signed (Month, Day, Year)

9/25/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Russell A Schilling 555 Cynwood Dr Easton MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Russell A. Schilling

Andrew Olcese
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32027

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia Putterman				2. Date of Death Month Day Year Sept. 25, 2000		3. Time of Death 11:15pm																					
	4a. Facility Name (If not institution, give street and number) 101 Odendhal Ave. #604				4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery																					
Funeral Director	5. Social Security Number 264-34-8000		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 24, 1927																					
	9. Birthplace (State or Foreign Country) Michigan		10a. State Md.		10b. County Montgomery		10c. City, Town or Location Gaithersburg																					
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 101 Odendhal Ave. #604		10f. Zip Code 20877		10g. Citizen of What Country? United States																					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: No		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Administrator		16b. Kind of Business/Industry Credit																							
	17. Father's Name (First, Middle, Last) Minard Enright				18. Mother's Name (First, Middle, Maiden Surname) Eva Unknown																							
	19a. Informant's Name/Relationship (Type, Print) Janet Jernigan (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20554 Afternoon Lane Germantown, Md. 20874																							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date Sept. 26, 2000		20c. Location - City or Town, State Alexandria, Va.																					
	21. Signature of Funeral Service Licensee Curtis E. Day				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877																							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																											
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Apnea</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> <td>1 Hour</td> </tr> <tr> <td>b.</td> <td>Metastatic Lung Cancer</td> <td>2 Years</td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Apnea	Approximate Interval Between Onset and Death		Due to (or as a consequence of):	1 Hour	b.	Metastatic Lung Cancer	2 Years		Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)	a.	Apnea	Approximate Interval Between Onset and Death																								
		Due to (or as a consequence of):	1 Hour																									
b.		Metastatic Lung Cancer	2 Years																									
		Due to (or as a consequence of):																										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a consequence of):																										
	d.	Due to (or as a consequence of):																										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																												
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																						
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																												
29f. Signature and title of certifier J. Hamlin				29c. License number RES-000		29d. Date signed (Month, Day, Year) September 26, 2000																						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Thambi M.D. 8901 Wisconsin Ave. Bethesda, Md. 20889																												
31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature B. Sparks																										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32028

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nellie E. Polutchko				2. Date of Death Month Day Year September 20, 2000		3. Time of Death 8:00 PM	
	4a. Facility Name (If not Institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 184-38-9430		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 6, 1912	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 10714 Potomac Tennis Lane		10f. Zip Code 20854	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk				16b. Kind of Business/Industry Pharmacy		17. Father's Name (First, Middle, Last) Anthony Mazetis	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Mary Wickham				19a. Informant's Name/Relationship (Type, Print) Robert Polutchko/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9313 Belmart Road, Potomac, Maryland 20854	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Annunciation Cemetery		20c. Location - City or Town, State Pringle, Pennsylvania	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Will E. Brown M00672				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accidents Due to (or as a consequence of): Atherosclerosis Due to (or as a consequence of): Hypertensive Cardiomyopathy Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 Weeks Years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, Urosepsis, Atrial Fibrillation, Osteoporosis Polymyalgia, Rheumatism, Seizures due to cerebrovascular accident				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 29c. License number D29256 29d. Date signed (Month, Day, Year) September 21, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jose Quiros, M.D. 4343 Montgomery Avenue, Bethesda, Maryland 20814				31. Date filed (Month, Day, Year) SEP 25 2000 32. Registrar's Signature B. Sparks			

ORIGINAL

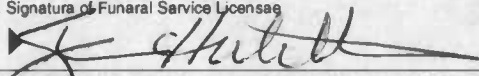
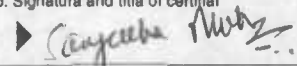
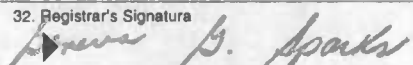
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32029

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Chloe Peters				2. Date of Death Month Day Year September 27, 2000				3. Time of Death 9:48 p.m.	
	4a. Facility Name (If not institution, give street and number) 1003 Paul Drive				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) April 11, 1933		9. Birthplace (State or Foreign Country) WV	
	10a. State MD		10b. County Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1003 Paul Drive		10f. Zip Code 20851		10g. Citizen of What Country? USA						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home						
17. Father's Name (First, Middle, Last) Sidney Kessler Curry		18. Mother's Name (First, Middle, Maiden Surname) Anna Thern								
19a. Informant's Name/Relationship (Type, Print) John W. Peters - husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Paul Drive, Rockville, MD 20851								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date 9/29/00		20c. Location - City or Town, State Beltsville, MD				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Rapp Funeral and Cremation Services Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, MD 20910								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of):							Approximate Interval Between Onset and Death 20 YEARS	
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D0055200		29d. Date signed (Month, Day, Year) SEPTEMBER 28, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANGEETHA MURTHY, M.D., 19504 DOCTORS DR., GERMANTOWN, MD 20874										
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32030

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Donald Penabare				2. Date of Death Month Sept. Day 25, Year 2000		3. Time of Death 12:55p.	
	4a. Facility Name (If not institution, give street and number) 9224 St. Andrews Place				4b. City, Town, or Location of Death College Park		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 087-22-9865	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 27, 1932		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location College Park		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 9224 St. Andrews Place				10f. Zip Code 20740		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-1955		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Textron Home Light		
17. Father's Name (First, Middle, Last) Anthony Penabare				18. Mother's Name (First, Middle, Maiden Surname) Julia Fusco				
19a. Informant's Name/Relationship (Type, Print) Irene Penabare (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Location - City or Town, State Sept. 29, 2000 Rye Brook, New York		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Progressive Lung Cancer Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 8 months Dua to (or as a consequence of): Dua to (or as a consequence of): Dua to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number 035174		29d. Date signed (Month, Day, Year) September 25, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marcia Will, M.D. 7525 Greenway Center Drive, #205 Greenbelt, Maryland 20770								
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32031

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SIMON PEARLMAN						2. Date of Death Month Day Year SEPT 22, 2000		3. Time of Death 20:09	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL						4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 099-07-9963		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) NOV 16, 1916		9. Birthplace (State or Foreign Country) NEW YORK	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 2013 RANDOLPH ROAD #101				10f. Zip Code 20902		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RETAIL			16b. Kind of Business/Industry GROCERY		
	17. Father's Name (First, Middle, Last) SAMUEL PEARLMAN						18. Mother's Name (First, Middle, Maiden Surname) MINNIE MANISHKAS			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) BESS PEARLMAN/WIFE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 RANDOLPH ROAD #101, SILVER SPRING, MD 20902			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT LEBANON CEMETERY		Date SEPT 24, 2000		20c. Location - City or Town, State ADELPHI, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. UPPER GASTROINTESTINAL HEMMORRHAGE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCVD									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and Title of Certifier 				29c. License number D 24348		29d. Date signed (Month, Day, Year) 9/22/2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEVEN GRUFFERMAN, MD 1500 FORREST GLEN RD, SILVER SPRING, MARYLAND 20910									
	31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32032

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DAISY MILDRED PHILLIPS

2. Date of Death

09 22 2000

3. Time of Death

0740

4a. Facility Name (If not institution, give street and number)

LAURELWOOD HEALTH CARE

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

CECIL

Funeral
Director

5. Social Security Number

220-26-3931

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/10/1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 FEDERAL ST. APT. 50

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ROLAND LEE SARD

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA LEE TALLEY

19a. Informant's Name/Relationship (Type, Print)

EMILY R. WAGNER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. BOX 91 ELK MILLS, MD 21920

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

TILGHMAN METHODIST CEM.

Date

9/26/00

20c. Location - City or Town, State

TILGHMAN, MD

21. Signature of Funeral Service Licensee

Joseph M. Ostrander

22. Name and Address of Facility

FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME
200 S. HARRISON ST. EASTON, MARYLAND 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. *Alzheimer's Disease*
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Monte Makous, MD

29c. License number

D-44783

29d. Date signed (Month, Day, Year)

September 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTE MAKOUS, MD 111 West High Street, ELKTON, MD 21921

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

James B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32033

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HOLTON HOWARD POTTER, JR.				2. Date of Death Month Day Year SEPT. 21, 2000		3. Time of Death 6:00pm	
	4a. Facility Name (If not institution, give street and number) 4070 HENNESSEE RD.				4b. City, Town, or Location of Death TRAPPE		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 216-56-1244		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 21, 1951	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County TALBOT		10c. City, Town or Location TRAPPE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4070 HENNESSEE RD.		10f. Zip Code 21673		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 73-78		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry TIRE SERVICE				
17. Father's Name (First, Middle, Last) HOLTON HOWARD POTTER, SR.				18. Mother's Name (First, Middle, Maiden Surname) MARGARET ELIZABETH COOPER				
19a. Informant's Name/Relationship (Type, Print) MARGARET POTTER/MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 WEST ST. EASTON, MD. 21601				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD. VETERANS CEME.		20c. Date 9/27/00		20d. Location - City or Town, State HURLOCK, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of):</p> <p>b. CONGESTIVE HEART FAILURE Due to (or as a consequence of):</p> <p>c. DIABETES II Due to (or as a consequence of):</p> <p>d.</p> </div> </div>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				
29c. License number D0055225				29d. Date signed (Month, Day, Year) 9/27/00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NOEL L. HUNTE MD 606 DUTCHMANS LANE EASTON, MD. 21601								
31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No.

00 32034

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Paolozzi					2. Date of Death Month September Day 29 Year 2000		3. Time of Death 8:10 PM		
	4a. Facility Name (If not institution, give street and number) Mariner Health Care of Laurel					4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 057-28-3852		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) April 19, 1915		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
10a. State MD		10b. County Prince George's		10c. City, Town or Location Laurel				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 14200 Laurel Park Drive					10f. Zip Code 20707		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Vincent Florenze					18. Mother's Name (First, Middle, Maiden Surname) Carmela Lazzaro					
19a. Informant's Name/Relationship (Type, Print) Vincent Paolozzi/ Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Patrician Lane, Brownville, NY 13619					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Calvary Cemetery		Date 10/3/00		20c. Location - City or Town, State New Hartford, NY			
21. Signature of Funeral Service Licensee MO1103					22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20708					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 15%; text-align: center;"> <p>e. Congestive Heart Failure</p> <p>Due to (or as a consequence of):</p> <p>b. Coronary Artery Disease</p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 5%;"> <p>1 week</p> <p>2 years</p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Bennett So MD					29c. License number D54488		29d. Date signed (Month, Day, Year) 9-30-2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Bennett So, MD 8317 Cherry Lane, Laurel, MD 20707										
31. Date filed (Month, Day, Year) OCT - 2 2000			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32035

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sophie Elizabeth Palmer

2. Date of Death

September 19 2000

3. Time of Death

0530

Funeral
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

220-26-7909

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 15 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

139 Second Street

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Hotson King

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Polk

19a. Informant's Name/Relationship (Type, Print)

Debra Purnell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

139 Second Street Salisbury, Md. 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St Mary's Cemetery

Date

9/26/00

20c. Location - City or Town, State

Princess Anne, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

025674

29d. Date signed (Month, Day, Year)

9/20/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J A Cockey, MD 100 Power St, Salisbury, Md. 21804

31. Date filed (Month, Day, Year)

SEP 22 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Sophie Palmer 220-26-7909

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a pt.II per phys. G788 10/26/00 yf

Certificate of Death

Reg. No.

00 32036

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Jane Ross				2. Date of Death Month Day Year September 19, 2000				3. Time of Death 524pm	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 480-16-9225	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 8, 1917	9. Birthplace (State or Foreign Country) Iowa			
	Usual Residence of Decedent									
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3112 Gracefield Rd #222				10f. Zip Code 20904		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Fred A. Criley				18. Mother's Name (First, Middle, Maiden Surname) Nancy Pearl Allison						
19a. Informant's Name/Relationship (Type, Print) Charles Ross /Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Gracefield, Silver Spring, MD 20904						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Sep 23 2000		20c. Location - City or Town, State Beltsville, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Massive pulmonary embolism, main pulmonary arteries-bilateral Acute Cardiac Arrest Due to (or as a consequence of): Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> </div>								Approximate Interval Between Onset and Death Seconds Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. non smoker								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  MD				29c. License number D53411		29d. Date signed (Month, Day, Year) September 20, 2000				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) J. C. Shesadri M.D. 3060 Mitchellville Rd. #103, Bowie, MD 20716										
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32037

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSS ROSENBERG				2. Date of Death Month Day Year SEPTEMBER 24, 2000		3. Time of Death 7:50 AM	
	4a. Facility Name (If not institution, give street and number) CASEY HOUSE				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 217-24-7543	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) NOVEMBER 20, 1928		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.	10b. County MONTGOMERY	10c. City, Town or Location NORTH BETHESDA			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 11430 Strand Drive #413				10f. Zip Code 20852		10g. Citizen of What Country? U.S.A	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BUSINESS OWNER				16b. Kind of Business/Industry AUTOMOTIVE REPAIR	
	17. Father's Name (First, Middle, Last) ALVIN ROSENBERG				18. Mother's Name (First, Middle, Maiden Surname) NORMA SACHS			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) WANEETA L. ROSENBERG WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11430 Strand Drive #413 N. BETHESDA, MD..20852			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematorium or other place) JUDAN MEMORIAL GARDENS		Date SEPTEMBER 26, 2000		20c. Location - City or Town, State OLNEY, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD. 20852			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last NON SMALL CELL LUNG CANCER Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 1yr 6yrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTHYROIDISM							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
State Registrar	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
10	29b. Signature and title of certifier 		29c. License number DO9470		29d. Date signed (Month, Day, Year) SEPTEMBER 24, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EUGENE P. LIBRE M.D. 10400 CONNECTICUT AVE. KENSINGTON, MD. 20895							
State Registrar	31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32038

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer Earl Roos				2. Date of Death Month Day Year September 26, 2000				3. Time of Death 2:50 AM	
	4a. Facility Name (If not institution, give street and number) 4516 Dresden Street				4b. City, Town, or Location of Death Kensington				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 205-16-0861		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) July 7, 1922		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Kensington	
To Be Completed by Funeral Director	10e. Street and Number 4516 Dresden Street				10f. Zip Code 20895		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Intelligence Research Specialist				16b. Kind of Business/Industry United States Government	
	17. Father's Name (First, Middle, Last) August Roos				18. Mother's Name (First, Middle, Maiden Surname) Rose Van Kokelberg					
	19a. Informant's Name/Relationship (Type, Print) Louise G. Roos/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4516 Dresden Street, Kensington, Maryland 20895					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grandview Cemetery		Date September 30, 2000		20c. Location - City or Town, State Johnstown, Pennsylvania			
	21. Signature of Funeral Service Licensee  MO1126				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RENAL CELL CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D09577				29d. Date signed (Month, Day, Year) September 26, 2000		
29b. Signature and title of certifier  Richard H. Pollen, M.D.										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard H. Pollen, M.D. 10400 Connecticut Avenue #606, Kensington, Maryland 20895										
31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32039

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARDEANIA REDDIX		2. Date of Death SEPT. 27, 2000		3. Time of Death 7:07 AM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Location of Death Takoma Park		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 217-32-0244	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 14, 1931
	9. Birthplace (State or Foreign Country) Wash. DC					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County Pr. Geo.	
	10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 5212 57th Avenue		10f. Zip Code 20781		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: Black					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home	
	17. Father's Name (First, Middle, Last) Jasper Jordan		18. Mother's Name (First, Middle, Maiden Surname) Mary Bright			
	19a. Informant's Name/Relationship (Type, Print) Emory E. Reddix (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 57th Ave., Hyattsville, MD 20781			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ash Memorial Cemetery		20c. Location - City or Town, State 10/2/00 Sandy Spring, MD	
	21. Signature of Funeral Service Licensee <i>George L. Snowden</i>		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiorespiratory arrest Due to (or as a consequence of): b. Chronic obstructive lung disease Due to (or as a consequence of): c. Sarcoidosis Due to (or as a consequence of): d.					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D19891		29d. Date signed (Month, Day, Year) 9/27/2000	
	30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Abraham B. Dabele 4404 Queensbury Rd Riverdale MD 20737					
	31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature <i>[Signature]</i>			

amend
18 10/10/00
ded

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32040

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John G. Rapp				2. Date of Death Month Day Year October 3 2000		3. Time of Death 11:00am				
	4a. Facility Name (If not institution, give street and number) 9966 Oak Lea Ct.				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard				
Funeral Director	5. Social Security Number 215 07 2643		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 10, 1908		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 2826 Pinewick Road				10f. Zip Code 21042		10g. Citizen of What Country? United States					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehousing Supervisor			16b. Kind of Business/Industry Retail				
17. Father's Name (First, Middle, Last) John Rapp				18. Mother's Name (First, Middle, Maiden Surname) Lula E. Peaston							
19a. Informant's Name/Relationship (Type, Print) Leonard Rapp/Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 Pinewick Road Ellicott City, MD 21042-2204							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Western Cemetery		20c. Date 10-6-2000		20d. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee Sherrill A. Gellins - 21044				22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Aspiration Pneumonia Due to (or as a consequence of): b. Parkinsonism Due to (or as a consequence of): c. Congestive Heart Failure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death Days Years Years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Group Home							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier		29c. License number D22856		29d. Date signed (Month, Day, Year) October 4, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Debra J. L. ... 11055 Little ... Columbia ...											
31. Date filed (Month, Day, Year) OCT 05 2000				32. Registrar's Signature Betina B. Sparks							

Baltimore, Maryland 21215-0020

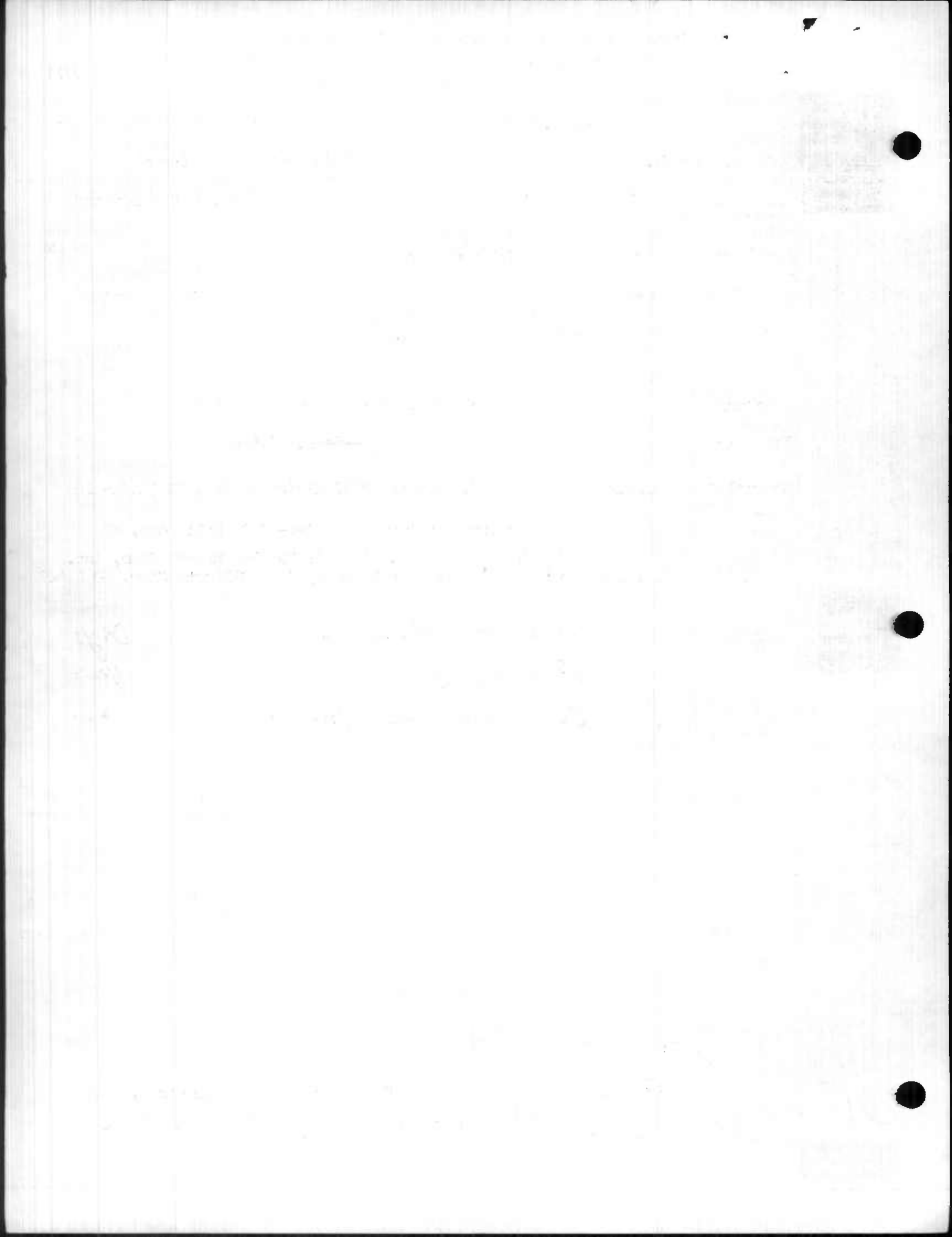
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32041

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALLENE VEREEN RUSS

2. Date of Death

09 15 2000

3. Time of Death

8:45 PM

4a. Facility Name (If not institution, give street and number)

CORSICA HILLS NURSING HOME

4b. City, Town, or Location of Death

CENTREVILLE

4c. County of Death

QUEEN ANNE'S

Funeral
Director

5. Social Security Number

195-42-1388

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

8/3/1918

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

VA

10b. County

N/A

10c. City, Town or Location

VIRGINIA BEACH

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1480 REYNARD DRIVE

10f. Zip Code

23451

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL G. VEREEN

18. Mother's Name (First, Middle, Maiden Surname)

KATHERINE VEREEN

19a. Informant's Name/Relationship (Type, Print)

JAMES A. RUSS / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 THE POINT LANE STEVENSVILLE, MD 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR

Date

9/18/00

20c. Location - City or Town, State

STEVENSVILLE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME

106 SHAMROCK ROAD CHESTER, MD 21619

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Lung Cancer

Approximate Interval Between Onset and Death

3M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

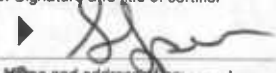
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D32036

29d. Date signed (Month, Day, Year)

9/18/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gay J. Sparks 2100 P. Banks Ave Chesapeake, MD 21619

31. Date filed (Month, Day, Year)

SEP 19 2000

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32042

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elmer W. Ruby Sr.			2. Date of Death Month Day Year SEPTEMBER 12, 2000		3. Time of Death 8:29AM
	4a. Facility Name (If not institution, give street and number) Memorial Hospital ER			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany
Funeral Director	5. Social Security Number 176-14-7299	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day, Year) Jul 20, 1912
	9. Birthplace (State or Foreign Country) PA					
To Be Completed by Funeral Director	10a. State MD		10b. County Allegany		10c. City, Town or Location Flintstone	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 19900 Bennett Berry Lane		10f. Zip Code 21530		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify white					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) contractor		16b. Kind of Business/Industry home improvement	
	15. Decedent's Education (Specify only highest grade completed) 12 Collega (1-4 or 5+)					
	17. Father's Name (First, Middle, Last) Russell Ruby		18. Mother's Name (First, Middle, Maiden Surname) Blanche (Fetters)			
	19a. Informant's Name/Relationship (Type, Print) Robert Ruby son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19411 Dickerson Hollow; Flintstone MD 21530			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Odd Fellows Cemetery		20c. Location - City or Town, State 9/15/ Flintstone, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of):					1 MINUTE
	b. CORONARY HEART DISEASE Due to (or as a consequence of):					10 YEARS
	c. _____ Due to (or as a consequence of):					
	d. _____ Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Describe how injury occurred		28b. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.		29c. License number D-23334	29d. Date signed (Month, Day, Year) SEPTEMBER 14th 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINESH B. SAHI, M.D.; 205 JOHNSON HTS MED BLDG, CUMBERLAND, MD 21502.						
31. Date filed (Month, Day, Year) SEP 19 2000		32. Registrar's Signature 				

ORIGINAL

Handwritten text, possibly a signature or initials.

SEP 18 1932

Amended #18, 7/18/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN MICHAEL RYAN				2. Date of Death Month Day Year SEPTEMBER 17 2000				3. Time of Death 7:35 P. M.	
	4a. Facility Name (If not institution, give street and number) 10114 CRYSTAL LANE, NW				4b. City, Town, or Location of Death FROSTBURG				4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 219 56 9501		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50		8. Date of Birth (Month, Day, Year) APRIL 18 1950		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location FROSTBURG				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number 10114 CRYSTAL LANE, NW				10f. Zip Code 21532				10g. Citizen of What Country? U.S.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RADIOLOGIC TECHNOLOGIST				16b. Kind of Business/Industry HOSPITAL		
17. Father's Name (First, Middle, Last) VICTOR W. RYAN, SR.				18. Mother's Name (First, Middle, Maiden Surname) MARGARET NAOMI GREEN						
19a. Informant's Name/Relationship (Type, Print) CAROLE RYAN / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 ORMAND STREET, FROSTBURG, MD 21532						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ECKHART CEMETERY		Date 9/20/00		20c. Location - City or Town, State ECKHART, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. ARTERIOSCLEROTIC HEART DISEASE Due to (or as a consequence of): b. TYPE 1 DIABETES Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death YEARS YEARS		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D09157				29d. Date signed (Month, Day, Year) September 17, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL SNOW, M.D., 124 W. 3RD ST., CUMBERLAND, MD 21502										
31. Date (Month, Day, Year) SEP 21 2000				32. Registrar's Signature 						

James P. Jones

SEP 1 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32044

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDNA E ROSS				2. Date of Death Month Day Year September 16 2000		3. Time of Death 1459	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 216-20-7828	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 16, 1926	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Worcester	10c. City, Town or Location Ocean City			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 12832 Whisper Trace Drive			10f. Zip Code 21842		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistical Supervisor		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Ronald Clarke			18. Mother's Name (First, Middle, Maiden Surname) Emma Wallberg				
	19a. Informant's Name/Relationship (Type, Print) Barbara E. Mills/Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3898 Kingston Oak Cove, Oviedo, FL 32765				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 9/18/00	20c. Location - City or Town, State Salisbury, MD		
	21. Signature of Funeral Service Licensee Karl R. Downey			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Intestinal Ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier David Sackler MD				29c. License number D0051743		29d. Date signed (Month, Day, Year) 09/16/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID Sackler 145 E. Carroll St, Salisbury Md, 21801								
31. Date filed (Month, Day, Year) SEP 19 2000		32. Registrar's Signature B. Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32045

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret G. Roberts				2. Date of Death Month Day Year September 15, 2000		3. Time of Death 1645																										
	4a. Facility Name (If not institution, give street and number) Peninsula regional Medical Center				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico																										
Funeral Director	5. Social Security Number 221-03-8996	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9/2/1914		9. Birthplace (State or Foreign Country) Maryland																									
	Usual Residence of Decedent																																
To Be Completed by Funeral Director	10e. State MD	10b. County Wicomico	10c. City, Town or Location Delmar			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																											
	10e. Street and Number 28845 Adkins Road			10f. Zip Code 21875		10g. Citizen of What Country? USA																											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria		16b. Kind of Business/Industry High School																												
	17. Father's Name (First, Middle, Last) J.C. Green				18. Mother's Name (First, Middle, Maiden Surname) Eva Kenny Green																												
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) John L. Roberts, Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28845 Adkins Road, Delmar, MD 21875																													
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stephens Cemetery		20c. Location - City or Town, State Delmar, DE		20d. Date 9/18/00																										
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove Street, Delmar, DE 19940																													
	23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) e. <u>Cardiac arrest</u> Due to (or as a consequence of): f. <u>Dementia</u> Due to (or as a consequence of): g. <u>Hypertension</u> Due to (or as a consequence of): h. _____ Due to (or as a consequence of): </td> <td rowspan="4"> { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td colspan="6"></td> </tr> <tr><td colspan="6"></td></tr> <tr><td colspan="6"></td></tr> <tr><td colspan="6"></td></tr> </table>								Immediate Cause (Final disease or condition resulting in death) e. <u>Cardiac arrest</u> Due to (or as a consequence of): f. <u>Dementia</u> Due to (or as a consequence of): g. <u>Hypertension</u> Due to (or as a consequence of): h. _____ Due to (or as a consequence of):	{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																							
Immediate Cause (Final disease or condition resulting in death) e. <u>Cardiac arrest</u> Due to (or as a consequence of): f. <u>Dementia</u> Due to (or as a consequence of): g. <u>Hypertension</u> Due to (or as a consequence of): h. _____ Due to (or as a consequence of):	{ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last																																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																											
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																											
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ER																															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number C-1 0005184		29d. Date signed (Month, Day, Year) 9/18/00																											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alex Jerome, M.D. 300 N. Dual Highway Laurel, DE 19956																																	
31. Date filed (Month, Day, Year) SEP 19 2000		32. Registrar's Signature 																															

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32046

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Kenneth E. Rudkin

2. Date of Death

Month
Sept.Day
28Year
2000

3. Time of Death

2:30 AM

4e. Facility Name (If not institution, give street and number)

Cherry Lane Nursing Home

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

217-24-3551

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 21, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9236 Whiskey Bottom Road

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Geodist

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Thomas Lowery Rudkin

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Pope

19a. Informant's Name/Relationship (Type, Print)

Roberta Eleanor McGough/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

324 Clearview Drive, Colonial Beach, VA 22443

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Memorial Pk

Date

10/2/00

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

End Stage Parkinson's Disease

Approximate
Interval Between
Onset and Death

Years

Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lasta. Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐
☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D25422

29d. Date signed (Month, Day, Year)

September 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Maggin, MD 13952 Baltimore Avenue, Laurel, Maryland 20707

31. Date filed (Month, Day, Year)

OCT - 2 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

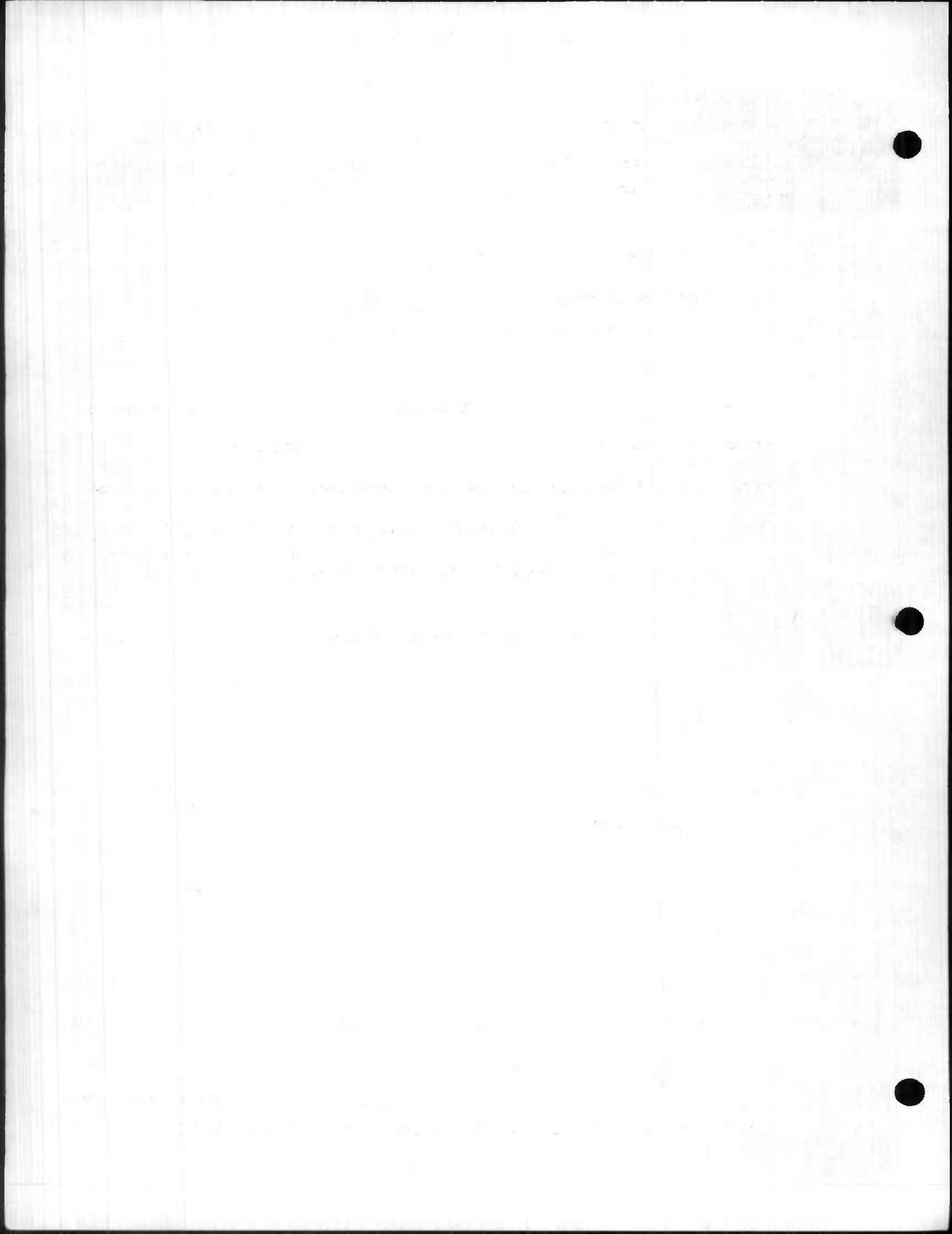
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32047

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl Wilson RIDDER				2. Date of Death Month Day Year Sept. 13, 2000				3. Time of Death 23:10	
	4a. Facility Name (If not institution, give street and number) 948 Mason School Road				4b. City, Town, or Location of Death Oakland				4c. County of Death Garrett	
Funeral Director	5. Social Security Number 215-36-9936		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Sept. 30, 1915		9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent		10a. State MD		10b. County Garrett	
To Be Completed by Funeral Director	10c. City, Town or Location Oakland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 948 Mason School Road		10f. Zip Code 21550	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farming	
	17. Father's Name (First, Middle, Last) Ernest ----- Ridder				18. Mother's Name (First, Middle, Maiden Surname) Dorothy ----- Baker				19a. Informant's Name/Relationship (Type, Print) Susan C. Piper/Daughter	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 560 Jasper Riley Road, Oakland, Maryland 21550				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens		20c. Date 9/17/00	
	20d. Location - City or Town, State Oakland, Maryland				21. Signature of Funeral Service Licensee Bridget H. [Signature]		22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 10 yr					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, type II Hx of cerebrovascular accident				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and Title of certifier Donald R. Richter, M.D.				29c. License number D30035						
29d. Date signed (Month, Day, Year) 09-14-00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550						
31. Date filed (Month, Day, Year) SEP 14 2000				32. Registrar's Signature [Signature]						

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5+IVA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 32048**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James J. Sullivan					2. Date of Death Month Day Year Sept. 20, 2000		3. Time of Death 7:30 PM.	
	4a. Facility Name (If not institution, give street and number) Manor Care Potomac					4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-05-7912		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jun. 6, 1903		9. Birthplace (State or Foreign Country) Washington, DC.
	Usual Residence of Decedent								
10a. State D.C.			10b. County N/A		10c. City, Town or Location Washington, D.C.			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4829 Upton St. NW.					10f. Zip Code 20016		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed			16b. Kind of Business/Industry Photo Processing	
17. Father's Name (First, Middle, Last) James Aloysius Sullivan					18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Turvey				
19a. Informant's Name/Relationship (Type, Print) Mary S. Mann - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4829 Upton St. NW., Washington, D.C. 20016				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery			Date 9/25/2000		20c. Location - City or Town, State Suitland, Md.	
21. Signature of Funeral Service Licensee Thomas E. Hornbaker					22. Name and Address of Facility Jospeh Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Advanced Age Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death 5 Minutes
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Sangeetha Murthy					29c. License number D0055200		29d. Date signed (Month, Day, Year) Sept. 21, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sangeetha Murthy, MD., 19504 Doctors Dr., Germantown, Md. 20874									
31. Date filed (Month, Day, Year) SEP 27 2000					32. Registrar's Signature Benita B. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32049

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet Mary Stancliff		2. Date of Death Month Day Year September 24, 2000		3. Time of Death 6:00 am
	4a. Facility Name (If not institution, give street and number) Springbrook Adventist Nursing & Rehab.		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 213-40-6574	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 105 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug 10, 1895		9. Birthplace (State or Foreign Country) England		
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 314 Northwest Drive		10f. Zip Code 20901		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) James William Bright		18. Mother's Name (First, Middle, Maiden Surname) Alice Maud Brook			
19a. Informant's Name/Relationship (Type, Print) Grand-Lawrence David Stancliff/ son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 Gideon Street, Bowie, MD 20720			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rock Creek Cemetery		20c. Location - City or Town, State Washington, DC	
21. Signature of Funeral Service Licensee Eric S. Scribner		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 week	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Paul Armstrong		29c. License number D 43237		29d. Date signed (Month, Day, Year) September 25, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, MD 14201 Laurel Park Drive Suite 102, Laurel, MD 20707					
31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32050

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marija Marta Sperlins				2. Date of Death Month Day Year September 21, 2000		3. Time of Death 9:40 PM													
	4a. Facility Name (If not Institution, give street and number) Collingswood Nursing Center				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery													
Funeral Director	5. Social Security Number 182-28-0311	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 23, 1908		9. Birthplace (State or Foreign Country) Latvia												
	Usual Residence of Decedent																			
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Cheverly		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 2811 Crest Avenue				10f. Zip Code 20785-2965		10g. Citizen of What Country? United States														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home														
17. Father's Name (First, Middle, Last) Not Available Fridenbergs-Ansbergs				18. Mother's Name (First, Middle, Maiden Surname) Not Available																
19a. Informant's Name/Relationship (Type, Print) Talivaldis Ivars Smits/P.O.A.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2811 Crest Avenue, Cheverly, Maryland 20785-2965																
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland														
21. Signature of Funeral Service Licensee  M00672				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Pneumonia</td> <td>2 Weeks</td> </tr> <tr> <td>b.</td> <td>Dementia</td> <td>Years</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Pneumonia	2 Weeks	b.	Dementia	Years	c.			d.		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Pneumonia	2 Weeks																	
	b.	Dementia	Years																	
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown														
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																
28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier  MD				29c. License number 45843		29d. Date signed (Month, Day, Year) September 22, 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sameh A. Aly, M.D. 481 North Frederick Avenue, #230, Gaithersburg, Maryland 20877																				
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32051

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth L. Smith				2. Date of Death Month Day Year September 23, 2000				3. Time of Death 1:05 PM	
	4a. Facility Name (If not institution, give street and number) 13208 Rippling Brook Drive				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 228-30-9937		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) May 31, 1931		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent				10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 13208 Rippling Brook Drive				10f. Zip Code 20906	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting				16b. Kind of Business/Industry Bank				17. Father's Name (First, Middle, Last) Fred Wilson Phoenix, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Francis Bryant				19a. Informant's Name/Relationship (Type, Print) Wanda L. Kirk/Cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3140 Pheasant Run, Ijamsville, Maryland 21754	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park				20c. Location - City or Town, State Rockville, Maryland	
	21. Signature of Funeral Service Licensee M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Unknown Primary Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier K. Wilson				29c. License number D33688	
	29d. Date signed (Month, Day, Year) September 25, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Wilson				31. Date filed (Month, Day, Year) SEP 27 2000	
	32. Registrar's Signature B. Sparks				33. Date of Death September 23, 2000				34. Time of Death 1:05 PM	

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32052

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Ethel Smith

2. Date of Death

Month Day Year
September 19, 2000

3. Time of Death

6:50 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-58-6939

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 16, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12707 Spring Tree Drive

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry W. A. Wellens

18. Mother's Name (First, Middle, Maiden Surname)

Mary Preuss

19a. Informant's Name/Relationship (Type, Print)

Albert Smith / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12707 Spring Tree Dr., Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Fort Lincoln Cemetery 09/23/00

Date

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Avenue
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. Anterior Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d. Hypertension

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D38435

29d. Date signed (Month, Day, Year)

Sept 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aaron Kenigsberg, M.D. 10313 Georgia Ave., #307, Silver Spring, Maryland 20902

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32053

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret L. Smith		2. Date of Death Month Day Year September 20, 2000		3. Time of Death 10:40AM
	4a. Facility Name (If not institution, give street and number) Mariner Health of Silver Spring		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 219-34-8660	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 10, 1925	9. Birthplace (State or Foreign Country) Kansas
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Olney		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 18403 Fairweather Drive		10f. Zip Code 20832		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry United States Government		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles E. Carman		18. Mother's Name (First, Middle, Maiden Surname) Alta May Potterf		
	19a. Informant's Name/Relationship (Type, Print) Kathleen S. Jordan / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18403 Fairweather Drive, Olney, Maryland 20832		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Mausoleum		20c. Location - City or Town, State Silver Spring, Maryland
	21. Signature of Funeral Service Licensee  M00689		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D09834		29d. Date signed (Month, Day, Year) September 21, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum, M.D. 3720 Farragut Avenue, Kensington, MD 20895					
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

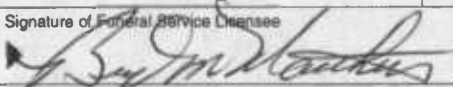
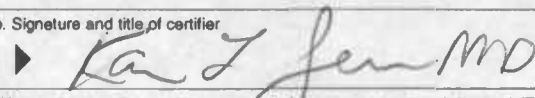
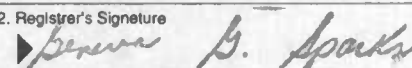
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

00 32054

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Muriel Singer			2. Date of Death Month Day Year Sept. 27, 2000		3. Time of Death 4:15A.	
	4a. Facility Name (If not institution, give street and number) Forest Glen Nursing Center			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 477-09-3562	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 21, 1916	9. Birthplace (State or Foreign Country) Minnesota
	Usual Residence of Decedent						
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 11805 Monticello Avenue			10f. Zip Code 20902		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Banker		16b. Kind of Business/Industry Banking		
17. Father's Name (First, Middle, Last) Harry Abramson				18. Mother's Name (First, Middle, Maiden Surname) Clara Wilenchick			
19a. Informant's Name/Relationship (Type, Print) Harriet Fredman - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) sameas #10			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial		Date Sept. 28, 2000		20c. Location - City or Town, State Olney, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) chronic obstructive pulmonary disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last chronic renal insufficiency peripheral vascular disease cardiac arrhythmia							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic renal insufficiency peripheral vascular disease cardiac arrhythmia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 29b. Signature and title of certifier  29c. License number D41341 29d. Date signed (Month, Day, Year) September 27, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen Jerome, M.D. 8700 Georgia Avenue, #400 Silver Spring, Maryland 20910							
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32055

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dinar Siahaan		2. Date of Death Month Day Year SEPTEMBER 21 2000		3. Time of Death 1234
	4e. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number 215-06-6200	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 25, 1952		9. Birthplace (State or Foreign Country) Indonesia		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 26 Cinzano Court		10f. Zip Code 20878		10g. Citizen of What Country? Indonesia
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Indonesian				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nanny		16b. Kind of Business/Industry Child Care
	17. Father's Name (First, Middle, Last) Dau Lat Siahaan		18. Mother's Name (First, Middle, Maiden Surname) Tiang Gur Napitupulu		
	19a. Informant's Name/Relationship (Type, Print) Walter Engelen / Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Irish Court, Gaithersburg, Maryland 20878		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland
	21. Signature of Funeral Service Licensee		22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904		
Physician /Medical Examiner	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. SEPTIC SHOCK				13 DAYS
	Due to (or as a consequence of): b. UROSEPSIS				13 DAYS
	Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RESPIRATORY FAILURE METASTATIC UTERINE CANCER				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of VIRENDRA K. SAXENA		29c. License number D30112		29d. Date signed (Month, Day, Year) SEPTEMBER 21 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIRENDRA K. SAXENA, 15600 MARATHON CIRCLE #301, GAITHERSBURG MD 20878				
	31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature B. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

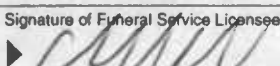
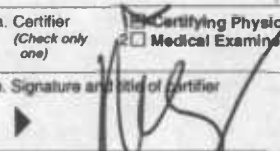
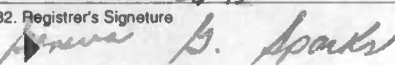
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32056

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NATHAN SHINDERMAN				2. Date of Death Month 9 Day 24 Year 2000				3. Time of Death 5:40 AM	
	4a. Facility Name (If not institution, give street and number) 11317 BERGER TERRACE				4b. City, Town, or Location of Death POTOMAC				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 109-07-9949		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 01-21-1915		9. Birthplace (State or Foreign Country) NEW YORK		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location POTOMAC	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 11317 BERGER TERRACE										
10f. Zip Code 20854										
10g. Citizen of What Country? USA										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: WHITE										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 5+										
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PERSONNEL MANAGER										
16b. Kind of Business/Industry US GOVERNMENT										
17. Father's Name (First, Middle, Last) MEYER SHINDERMAN										
18. Mother's Name (First, Middle, Maiden Surname) CEILA NOLOBOFF										
19a. Informant's Name/Relationship (Type, Print) JANET PINCUS/DAUGHTER										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11317 BERGER TERRACE, POTOMAC, MARYLAND 20854										
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS										
Date SEPT 26, 2000										
20c. Location - City or Town, State FALLS CHURCH, VA										
21. Signature of Funeral Service Licensee 										
22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury M										
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 										
29c. License number D24886										
29d. Date signed (Month, Day, Year) 9/25/00										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARK EIG, MD. 10801 Lockwood Drive #280 Silver Spring, Md. 20901										
31. Date filed (Month, Day, Year) SEP 27 2000										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32057

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHERINE SHER

2. Date of Death

September 27, 2000 2:00 A.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

3701 International Drive, Apt. 338

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

104-14-8290

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 20, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3701 International Drive, Apt. 338

10f. Zip Code

20906

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 Years

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Isadore Feder

18. Mother's Name (First, Middle, Maiden Surname)

Mary Davis

19a. Informant's Name/Relationship (Type, Print)

Judy S. Miller - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11213 Broad Green Drive, Potomac, Md. 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Forest Lawn Cemetery 9/29/2000 Pompano Beach, Florida

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald S. Stottmeyer

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. SEVERE CHRONIC OBSTRUCTIVE
Due to (or as a consequence of): PULMONARY DISEASESequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of certifier

Irving Mizes

29c. License number

D26571

29d. Date signed (Month, Day, Year)

9/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRVING MIZES, MD 4930 DELRAY AVE BETHESDA, MD 20814

State
Registrar

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32058

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James H. Salisbury				2. Date of Death Month Day Year September 24 2000		3. Time of Death 12:05 AM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 301-01-9865		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) March 4, 1923	
	9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6420 Winnepeg Road		10f. Zip Code 20817		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Freight Traffic Manager		16b. Kind of Business/Industry Railroad			
	17. Father's Name (First, Middle, Last) James Forrest Salisbury				18. Mother's Name (First, Middle, Maiden Surname) Grace May Rose			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Agnes K. Salisbury/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6420 Winnepeg Road, Bethesda, Maryland 20817			
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, Maryland		20d. Date Sept. 27, 2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee MO0198				22. Name and Address of Facility Robert A. Humphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal bleeding Due to (or as a consequence of): b. Mother's Therapy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death Hours Weeks			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Metastatic pancreatic cancer				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Alan S. Chanales				29c. License number 294453		29d. Date signed (Month, Day, Year) September 24, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan S. Chanales, M.D. 15225 Shady Grove Road, Rockville, Maryland 20850							
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000				32. Registrar's Signature B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32059

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID DANIEL SCHNEIDER						2. Date of Death Month Day Year Sept 24 2000		3. Time of Death 0800																							
	4a. Facility Name (If not institution, give street and number) Memorial Hospital						4b. City, Town, or Location of Death Easton		4c. County of Death Talbot																							
Funeral Director	5. Social Security Number 216-03-7126		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) DEC. 19, 1918		9. Birthplace (State or Foreign Country) MD																							
	Usual Residence of Decedent																															
10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																								
10e. Street and Number 303 PROSPECT AVE				10f. Zip Code 21601		10g. Citizen of What Country? USA																										
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER			16b. Kind of Business/Industry HOUSEHOLD REPAIR SERVICE																									
17. Father's Name (First, Middle, Last) BENJAMIN V. SCHNEIDER						18. Mother's Name (First, Middle, Maiden Surname) LOTTIE GOLDSTEIN																										
19a. Informant's Name/Relationship (Type, Print) KATHERINE LOUISE SCHNEIDER/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 PROSPECT AVE EASTON, MD 21601																												
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR		Date 9-25-2000		20c. Location - City or Town, State STEVENSVILLE, MD																								
21. Signature of Funeral Service Licensee JOHN R. MERCER				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601																												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Chronic obstructive pulmonary disease</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Congestive heart failure</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>coronary artery disease</td> <td>years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Chronic obstructive pulmonary disease	years	Due to (or as a consequence of):			b.	Congestive heart failure	years	Due to (or as a consequence of):			c.	coronary artery disease	years	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Chronic obstructive pulmonary disease	years																													
	Due to (or as a consequence of):																															
	b.	Congestive heart failure	years																													
	Due to (or as a consequence of):																															
c.	coronary artery disease	years																														
Due to (or as a consequence of):																																
d.																																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic gastrointestinal hemorrhage																																
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																
29b. Signature and title of certifier David J. Oliver, M.D.				29c. License number 039749		29d. Date signed (Month, Day, Year) 9/24/00																										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 Dutchmans Lane Easton MD 21601 David Oliver, M.D.																																
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature Sparks																														

David Schneider
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32060

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nellie Irene Smith				2. Date of Death Month Day Year September 18 2000		3. Time of Death 10:35AM	
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 216-01-8854		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min	8. Date of Birth (Month, Day, Year) Oct 2, 1915	9. Birthplace (State or Foreign Country) OH
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State WV		10b. County Hampshire		10c. City, Town or Location Augusta		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number HC 71 Box 1495				10f. Zip Code 26704		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Retired Seamstress		16b. Kind of Business/Industry Berkowitz Factory			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Robert Plummer				18. Mother's Name (First, Middle, Maiden Surname) Hazel (Streets)			
	19a. Informant's Name/Relationship (Type, Print) Marvin R Sponaugle Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 71 Box 1495; Augusta WV 26704			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gard		Date 9/21/		20c. Location - City or Town, State LaVale, MD	
	21. Signature of Funeral Service Licensee Nicholas J. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Cardio myopathy Due to (or as a consequence of): c. DM Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 23 dys.	
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Dr Samir Elion				29c. License number D40693		29d. Date signed (Month, Day, Year) September 20, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Samir Elion - 921 Seton Drive, Suite F, Cumberland, MD 21502							
	31. Date filed (Month, Day, Year) SEP 21 2000				32. Registrar's Signature Sparks			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature or initials.

0005 1 8 432

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32061

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Earl Elwood Smith

2. Date of Death

Month Day Year
Sep 24, 2000

3. Time of Death

04:00pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Cumberland Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegheny

5. Social Security Number

214-14-7728

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 16, 1922

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegheny

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

110 Mullen Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WW II
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:
X

14. Race - American Indian, Black, White, etc.

Specify:
white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Chessie System

17. Father's Name (First, Middle, Last)

Boyd U. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Lula (Smith)

19a. Informant's Name/Relationship (Type, Print)

Ada R. Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 Mullen Street; Cumberland, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cem 2000 Flintstone, MD

Date

9/27/

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James F. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cerebrovascular accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

carcinoma of colon

chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sunil K. Gupta

29c. License number

D33280

29d. Date signed (Month, Day, Year)

Sep 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil K. Gupta M.D. 625 Kent Avenue Cumberland MD 21502

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

MS

State
Registrar

Handwritten signature or initials.

SEP 21 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32062

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELSON HUDSON SMITH				2. Date of Death Month Day Year SEPTEMBER 15, 2000		3. Time of Death 6:51 PM
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 220-16-7328	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 21, 1925	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Florida	10b. County Sarasota	10c. City, Town or Location Venice			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1362 Brenner Park Drive			10f. Zip Code 34292		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WW II If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Manager		16b. Kind of Business/Industry Retail Lumber		
	17. Father's Name (First, Middle, Last) Nelson J. Smith			18. Mother's Name (First, Middle, Maiden Surname) Ruth Tucker			
	19a. Informant's Name/Relationship (Type, Print) Patricia R. Smith/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1362 Brenner Park Dr., Venice, FL 34292			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Gardens Cemetery		Date 9/19/00	20c. Location - City or Town, State Arlington, VA	
	21. Signature of Funeral Service Licensee David H. Compton MC1051			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock Due to (or as a consequence of): Refractory Ventricular Arrhythmia Due to (or as a consequence of): myocardial ischemia/infarction Due to (or as a consequence of): CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last year						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
29b. Signature and title of certifier Joseph Ruffetto, M.D.		29c. License number 20441		29d. Date signed (Month, Day, Year) SEPTEMBER 15, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Ruffetto, M.D. 400 EASTERN SHORE DR. SALISBURY, MD							
State Registrar	31. Date filed (Month, Day, Year) SEP 19 2000		32. Registrar's Signature B. Sparks				

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Handwritten notes in cursive script, possibly a list or a paragraph, located in the middle-left section of the page.

Handwritten signature or initials, possibly "J. M. L.", located in the bottom-right section of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32063

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John William Stark Sr				2. Date of Death Month Day Year August 24 2000		3. Time of Death 7:50pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-01-4080	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar 7 1916		9. Birthplace (State or Foreign Country) Mt Zion, Md
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md	10b. County Baltimore	10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1047 Lerew Way			10f. Zip Code 21205		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bon Secours Hospital		16b. Kind of Business/Industry Hospital			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles W. Stark				18. Mother's Name (First, Middle, Maiden Surname) Emma Sharpless			
	19a. Informant's Name/Relationship (Type, Print) Bessie J. Stark				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1047 Lerew Way Baltimore, Md 21205			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State Aug 27 2000 Swanton Md			
	21. Signature of Funeral Service Licensee David A. Burdock		22. Name and Address of Facility David A. Burdock Funeral Home 710 Church St. Kitzmiller, Md 21538					
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoxemia Due to (or as a consequence of): b. Aspiration Pneumonia Due to (or as a consequence of): c. Severe Dementia Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 hours 2 hours 5 years							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Jude Muneses MD				29c. License number DS3462		29d. Date signed (Month, Day, Year) 8/25/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jude Muneses MD 7845 Oakwood Road Balto. MD 21061								
31. Date filed (Month, Day, Year) AUG 29 2000				32. Registrar's Signature A. [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32064

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Myrtle Ina Spencer						2. Date of Death Month Day Year Aug. 26, 2000		3. Time of Death 8:15 AM	
	4a. Facility Name (If not institution, give street and number) Maust Home Care Center						4b. City, Town, or Location of Death Accident		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 220-52-9417		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 15, 1904		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number Turner Douglas Road				10f. Zip Code 21550		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home		
	17. Father's Name (First, Middle, Last) Ellsworth ----- Lemasters						18. Mother's Name (First, Middle, Maiden Surname) Thedoshia Belle Beverlin			
	19a. Informant's Name/Relationship (Type, Print) Carl M. Spencer/Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Highland Drive, Oakland, Md. 21550			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens		20c. Date 8/29/00		20d. Location - City or Town, State Oakland, Md. 21550	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. atherosclerotic cardiovascular disease yrs Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of CVA									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) personal care home										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred home		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D30035		29d. Date signed (Month, Day, Year) 08-28-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550										
31. Date filed (Month, Day, Year) AUG 29 2000		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32065

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Lansdale SWEITZER				2. Date of Death Month Day Year September 10, 2000		3. Time of Death 8:45 AM		
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett		
Funeral Director	5. Social Security Number 214-16-2545		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 17, 1922		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10e. State: MD 10b. County: Garrett 10c. City, Town or Location: Oakland 10d. Inside City Limits: 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		11. Merital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 7 College (1-4 or 5+):		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner		16b. Kind of Business/Industry Grain Processing	
17. Father's Name (First, Middle, Last) Edward Theodore Sweitzer				18. Mother's Name (First, Middle, Maiden Surname) Anna Florence Sweitzer				19a. Informant's Name/Relationship (Type, Print) M. Louise Sweitzer/Wife	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3508 Broadford Road, Oakland, Maryland 21550				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Deer Park Cemetery		20c. Location - City or Town, State Deer Park, Maryland	
21. Signature of Funeral Service licensee B. H. H. H.				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, MD 21550				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. coronary artery disease years b. high blood pressure years c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier T. Johnson				29c. License number D15333		29d. Date signed (Month, Day, Year) 9/11/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550				31. Data filed (Month, Day, Year) SEP 12 2000				32. Registrar's Signature B. H. H. H.	

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

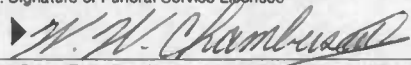
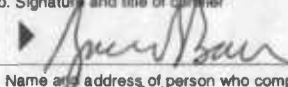
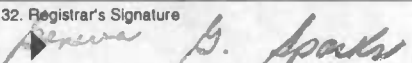
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32066

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAUL H. TRAUTWEIN				2. Date of Death Month SEPT. Day 27 Year 2000		3. Time of Death 5:00 PM		
	4a. Facility Name (If not institution, give street and number) 822 BRICE RD.				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 123-16-0652		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 2, 1926		
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 822 BRICE RD.		10f. Zip Code 20852		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SYSTEMS ANALYST		16b. Kind of Business/Industry F.D.A.		17. Father's Name (First, Middle, Last) PAUL K. TRAUTWEIN		18. Mother's Name (First, Middle, Maiden Surname) ETHEL HAMILTON	
19a. Informant's Name/Relationship (Type, Print) WILL TRAUTWEIN/SON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3511 BANK ST., BALTIMORE, MD. 21224		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHAMBERS CREMATORY		20c. Location - City or Town, State 9/29/00 RIVERDALE, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYOCARDIAL INFARCTION		Approximate Interval Between Onset and Death 1 hr			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease		23c. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number MD D 21340		29d. Date signed (Month, Day, Year) SEPT. 28, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND BASS 3941 FERRARA DR WHEATON, MD 20906		31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

REACH, OCT 17, 1964

TO: J. L. RICH

FROM: J. L. RICH

RE: [illegible]

[illegible]

[illegible]

RE: [illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32067

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley S. Townsend					2. Date of Death Month Day Year Sept. 29, 2000		3. Time of Death 5:10 AM			
	4a. Facility Name (If not institution, give street and number) Wilson Health Care Center					4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery			
Funeral Director	5. Social Security Number 493-12-6859		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) March 9, 1912		9. Birthplace (State or Foreign Country) Michigan		
	Usual Residence of Decedent					10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					10e. Street and Number 401 Russell Avenue, # 219		10f. Zip Code 20877		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home				
	17. Father's Name (First, Middle, Last) Carmi Sharp					18. Mother's Name (First, Middle, Maiden Summa) Hazel Thurston					
	19a. Informant's Name/Relationship (Type, Print) Penelope T. Jones/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4804 Jamestown Road, Bethesda, Maryland 20816					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 9/29/00 Alexandria, Virginia		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory failure</u> Due to (or as a consequence of) b. <u>Chronic obstructive pulmonary disease</u> Due to (or as a consequence of) c. <u></u> Due to (or as a consequence of) d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 days		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> <u>Pulmonary hypertension</u> <u>Cachexia</u>								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	25. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day, Year)		27b. Time of Injury M		27c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		27d. Describe how injury occurred
27e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27f. Location (Street and Number or Rural Route Number, City or Town, State)		28a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28b. Signature and title of certifier 		28c. License number 04115		28d. Date signed (Month, Day, Year) September 29, 2000	
29. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, M.D., 6320 Democracy Blvd., Bethesda, Maryland 20817											
30. Date filed (Month, Day, Year) SEP 29 2000		31. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32068

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie Tillery

2. Date of Death
Month Day Year
September 23, 20003. Time of Death
3:50 PM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

068-22-9444

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 25, 1911

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7525 Carroll Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Garment District

17. Father's Name (First, Middle, Last)

Berry Tillery

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Exum

19a. Informant's Name/Relationship (Type, Print)

Angela Satterthwaite/ Great-Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6728 2nd Street, N.W. Washington, D.C. 20012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

9/27/00

20c. Location - City or Town, State

Beltsville, Md.

21. Signature of Funeral Service Licensee

▶ *Joanna E. Elliberry*

22. Name and Address of Facility

McGuire Funeral Service, Inc.
7400 Georgia Avenue, N.W. Wash., D.C. 20012

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC ENCEPHALOPATHY

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. ARTERIOSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

▶ *Joseph B. Mizgerd, M.D.*

29c. License number

D0008425

29d. Date signed (Month, Day, Year)

SEPT. 24, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOSEPH B. MIZGERD, M.D. 7600 CARROLL AVE., TAKOMA PARK, MD 20912

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

▶ *Joseph B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32069

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rodney John Twigg

2. Date of Death

Month 9 Day 21 Year 2000

3. Time of Death

19:37

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

370-38-7498

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year Feb 16, 1939

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12012B Bedford Road NE

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

construction worker

16b. Kind of Business/Industry

Local 616

17. Father's Name (First, Middle, Last)

Calvin E. Twigg

18. Mother's Name (First, Middle, Maiden Surname)

Viola C (Skelley)

19a. Informant's Name/Relationship (Type, Print)

Lovie E. Twigg

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12012B Bedford Road NE; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Sunset Memorial Park

Date

9/25/00 Cumberland, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.
Cumberland, MD 2150223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. CARDIO-RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. PROBABLE SEPSIS

Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECTAL CARCINOMA, COPD, MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

DR. KENNETH ROCK

29c. License number

D30197

29d. Date signed (Month, Day, Year)

SEPTEMBER 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KENNETH ROCK MEMORIAL HOSPITAL SUITE 402 CUMBERLAND, MD 21502

State
Registrar

31. Date (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Benjamin S. Sparks

RODNEY TWIGG 370-38-7498

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

X

X

X

X

Handwritten signature or initials

SEP 2 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32070

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE ANN TRESSLER				2. Date of Death Month Day Year AUGUST 31, 2000		3. Time of Death 2:45 AM			
	4a. Facility Name (If not institution, give street and number) 2209 HUTTON ROAD				4b. City, Town, or Location of Death OAKLAND		4c. County of Death MARYLAND GARRETT			
Funeral Director	5. Social Security Number 216-56-1808		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB 2, 1951	9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County GARRETT		10c. City, Town or Location OAKLAND		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 2209 HUTTON ROAD				10f. Zip Code 21550		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SECRETARY		16b. Kind of Business/Industry OIL COMPANY					
	17. Father's Name (First, Middle, Last) CHARLES WINDSOR HASTINGS				18. Mother's Name (First, Middle, Maiden Surname) LOTTIE BLANCHE APPLE					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PARKE W. TRESSLER - HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 HUTTON ROAD OAKLAND, MD 21550					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EAST NEW MARKET CEM.		20c. Location - City or Town, State 8/2/00 EAST NEW MARKET, MD					
	21. Signature of Funeral Service Licensee  MO0167				22. Name and Address of Facility P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. VULVAR CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 3 YEARS		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier  MD				29c. License number D 27205		29d. Date signed (Month, Day, Year) AUGUST 31, 2000				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KARL E. SCHWALM, M.D. 311 N. FOURTH ST. OAKLAND, MD 21550										
31. Date filed (Month, Day, Year) AUG 31 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32071

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Shotwell Valeo

2. Date of Death

Month Day Year
September 22, 2000 9:45 PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4550 North Park Ave. #T-201

4b. City, Town, or Location of Death

Chevy Chase

4c. County of Death

Montgomery

5. Social Security Number

578-50-0456

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 18, 1938

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4550 North Park Ave. #T-201

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Committee Staff

16b. Kind of Business/Industry

US Senate

17. Father's Name (First, Middle, Last)

Rowland Sheppard Oliver

18. Mother's Name (First, Middle, Maiden Surname)

Abigail Seabrook Hanahan

19a. Informant's Name/Relationship (Type, Print)

Francis Valeo /Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4550 North Park Ave. #T-201, Chevy Chase, MD

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

Sep 26
2000

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Hall

22. Name and Address of Facility

Rapp Funeral & Cremation Services
933 Gist Avenue Silver Spring, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Small Bowel Obstruction

a. Due to (or as a consequence of):

Ovarian Cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Beverly L. Hall

29c. License number

D29142

29d. Date signed (Month, Day, Year)

September 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Boice M.D. 10301 Georgia Ave, Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

Beverly L. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32072

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD P VANCE				2. Date of Death Month Day Year September 18, 2000				3. Time of Death 2:15 AM		
	4a. Facility Name (If not institution, give street and number) 913 W. Schumaker Manor Drive				4b. City, Town, or Location of Death Salisbury				4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 577-28-9818		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) August 20, 1924		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 913 W. Schumaker Manor Drive				10f. Zip Code 21804				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-1947		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) First Level Management				16b. Kind of Business/Industry C & P Telephone Co.			
17. Father's Name (First, Middle, Last) James H. Vance				18. Mother's Name (First, Middle, Maiden Surname) Mary M. Parker							
19a. Informant's Name/Relationship (Type, Print) Dorothy Mae Vance/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 W. Schumaker Manor Dr., Salisbury, MD 21804							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery			20c. Location - City or Town, State Salisbury, MD					
21. Signature of Funeral Service Licensee Kell K. Dawey				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Insufficiency Due to (or as a consequence of): b. Amyotrophic Lateral Sclerosis Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death hours 12/99	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Hypertension, Cerebrovascular accident, Aortic sclerosis								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Hilda Imelio Houlikan, M.D.				29c. License number D04883				29d. Date signed (Month, Day, Year) 9-19-2000			
30. Name and address of person who completed cause of death (from 23a) (Type, Print) HILDA IMELIO HOULIKAN, M.D. 1405 S. Division St, Salisbury MD											
31. Date filed (Month, Day, Year) SEP 20 2000				32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15+IVA
HLCState
Registrar

John A. Smith

jhm
PETE
VIRTS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32073

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pete Virts		2. Date of Death Month Day Year SEPTEMBER 01, 2000		3. Time of Death 02:04 PM
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL		4b. City, Town, or Location of Death Cheverly		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 219-03-8143	6. Sex 2 M 2 F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) NOV. 3 1920		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD.		10b. County Prince Georges		10c. City, Town or Location Bowie	
10d. Inside City Limits XX Yes 2 No		10e. Street and Number 15908 Pennmanor Lane		10f. Zip Code 20716	
10g. Citizen of What Country? USA		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WW2 If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) maintenance engineer		16b. Kind of Business/Industry Hotel		17. Father's Name (First, Middle, Last) James W. Virts	
18. Mother's Name (First, Middle, Maiden Surname) Pansy Maynard		19a. Informant's Name/Relationship (Type, Print) Carole Alfie/ daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15908 Pennmanor Lane, Bowie, Md. 20716	
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Potomac Memorial Gardens		20c. Location - City or Town, State 09/07/00 Keyser, West Virginia	
21. Signature of Funeral Service Licensee F. Wayne Boal		22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Md. 21562			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries					
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
24a. Was an autopsy performed? 1 Yes 2 No					
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
25. Was case referred to medical examiner? 1 Yes 2 No					
26. Place of Death (Check only one) Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending investigation 2 X Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year) 9/1/00		28b. Time of Injury 12:15 PM	
28c. Injury at Work? 1 Yes 2 X No		28d. Describe how injury occurred Passenger of Motor Vehicle Impacts another vehicle 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) Greenbelt Road Prince Georges County, Md.	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier J. Pestaner, M.D.		29c. License number OCME		29d. Date signed (Month, Day, Year) SEPTEMBER 02, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) SEP - 6 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32074

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline Rosenfeld Wolfe

2. Date of Death

Month Day Year
Sep. 23, 2000

3. Time of Death

8:15 PM

4a. Facility Name (If not Institution, give street and number)

1801 E. Jefferson St., #408

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

138-38-1263

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Apr. 19, 1908

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1801 E. Jefferson St., #408

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Isaac Rosenfeld

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Levinson

19a. Informant's Name/Relationship (Type, Print)

Karl M. Wolfe/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 Dogwood Cir., Pinebrook, NJ 07058

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Elmwood Cemetery

Date

Sep. 26, 2000

20c. Location - City or Town, State

New Brunswick, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. stroke
Due to (or as a consequence of):b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0055258

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARY B. WILKS, MD Hersh Health Center 1801 East Jefferson Street Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32075

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Donald L. Wild

2. Date of Death

September 27, 2000

3. Time of Death

4:30 am

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

231-18-6636

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Mar 10, 1923

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3701 International Drive #549

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Montgomery County

Public Schools

17. Father's Name (First, Middle, Last)

Ernest A. Wild

18. Mother's Name (First, Middle, Maiden Surname)

Louise French

19a. Informant's Name/Relationship (Type, Print)

Linda W. Frew/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

66 Teal Circle, Berlin, MD 21811

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

9/30/00

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Immediate

Due to (or as a consequence of):

b. Coronary Atherosclerosis

5 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Peripheral Arterial Insufficiency

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 35045

29d. Date signed (Month, Day, Year)

September 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip G. Henjum, MD 3416 Olandwood Court #204, Olney, MD 20832

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32076

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carole Ann Hoover Whitney				2. Date of Death Month Day Year September 27, 2000				3. Time of Death 1:03 am	
	4a. Facility Name (If not institution, give street and number) 5908 Ipswich Road				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 442-36-1395		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) July 16, 1937		9. Birthplace (State or Foreign Country) Kansas	
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 5908 Ipswich Road		10f. Zip Code 20814		10g. Citizen of What Country? USA						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technical Writer		16b. Kind of Business/Industry Resume Service						
17. Father's Name (First, Middle, Last) George Franklin Hoover				18. Mother's Name (First, Middle, Maiden Surname) Viola M. Bell						
19a. Informant's Name/Relationship (Type, Print) Tara Lynn Gillam				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5908 Ipswich Road, Bethesda, MD 20814						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD						
21. Signature of Funeral Service Licensee William T. Boyd				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Respiratory Failure Due to (or as a consequence of):		b. Locally Advanced Lung Cancer Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier M. Markwell				29c. License number D 054722		29d. Date signed (Month, Day, Year) September 27, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Markwell, MD National Naval Medical Center, Bethesda, MD										
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature Benava B. Sparks								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32077

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOGAN EARL WHEELER		2. Date of Death Month Day Year SEPTEMBER 24, 2000		3. Time of Death 3:33 PM
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL		4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
Funeral Director	5. Social Security Number NONE	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. Months Days 5	8. Date of Birth (Month, Day, Year) Sept 19, 2000	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Germantown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 19308 Tattershall Drive		10f. Zip Code 20874		10g. Citizen of What Country? United States
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None		16b. Kind of Business/Industry None		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) David Earl Wheeler, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Gina Elizabeth McKean		
	19a. Informant's Name/Relationship (Type, Print) David E. Wheeler, Jr., Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19308 Tattershall Drive, Germantown, MD 20874		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extreme prematurity Due to (or as a consequence of): b. Pulmonary INTERSTITIAL Emphysema Due to (or as a consequence of): c. Pulmonary hemorrhage Due to (or as a consequence of): d. Severe Intraventricular hemorrhage		Approximate Interval Between Onset and Death 5 days 12 hours 2 days 2 days		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Respiratory Distress Syndrome Suspected Sepsis			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D 43225		29d. Date signed (Month, Day, Year) September 25, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHU NIGAM NEONATOLOGY, SHADY GROVE ADVENTIST HOSPITAL 20850					
State Registrar	31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32078

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUBY GENEVIEVE WATKINS				2. Date of Death Month Day Year SEPTEMBER 22, 2000		3. Time of Death 6:20 PM	
	4a. Facility Name (If not institution, give street and number) WILSON HEALTH CARE				4b. City, Town, or Location of Death GAITHERSBURG		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 215 62 5286		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth Month Day Year DEC. 28, 1913	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State VA.		10b. County LOUDOUN		10c. City, Town or Location HAMILTON	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 25 HAMILTON TERRACE DRIVE				10f. Zip Code 20158		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME			
	17. Father's Name (First, Middle, Last) GEORGE BRIGHAM				18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH CARTER			
	19a. Informant's Name/Relationship (Type, Print) RONALD L. WATKINS, SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 HAMILTON TERRACE DRIVE, HAMILTON, VA, 20158			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KEMPTOWN CEMETERY		Date 9/26/00		20c. Location - City or Town, State KEMPTOWN, MD.	
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bronchitis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
			28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Steven H. Dolinsky MD				29c. License number 20148		29d. Date signed (Month, Day, Year) Sept 23 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Ave Gaithersburg Md.							
	31. Date filed (Month, Day, Year) SEP 25 2000				32. Registrar's Signature Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32079

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marshall Waller

2. Date of Death

Month
Sept.Day
24Year
2000

3. Time of Death

10:50 Pm

4a. Facility Name (If not institution, give street and number)

Manor Care Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

420-52-6638

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 29, 1920

9. Birthplace (State or Foreign Country)

IL

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 Connecticut Ave.

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give WW-II
Year or Dates: WW-II13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Officer

16b. Kind of Business/Industry

Military / Army

17. Father's Name (First, Middle, Last)

James Waller

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Goldberg

19a. Informant's Name/Relationship (Type, Print)

Sylvia Waller /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8100 Connecticut Ave., Chevy Chase, MD 20815

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Data

Sep 26
2000

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly J. Hebert

22. Name and Address of Facility

Rapp Funeral & Cremation Services
933 Gist Avenue Silver Spring, MD23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sangeetha M.D.

29c. License number

D55200

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Murthy Sangeetha M.D. 19504 Doctors Dr., Germantown, MD 20874

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

B. Spahr

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
202-328-0000.Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32080

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

CHARLENE LATHROP WHITE

2. Date of Death

09 21 2000

3. Time of Death

5:10 AM

4a. Facility Name (If not institution, give street and number)

WILLIAM HILL MANOR

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

216-12-0649

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/02/1912

9. Birthplace (State or Foreign)

MISSOURI

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 DUTCHMAN'S LANE

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
416a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM BURRELL LATHROP

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE KILLINGER YOCUM

19a. Informant's Name/Relationship (Type, Print)

LYNNE JENNINGS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

281 EAST MILLAN CHULA VISTA, CA 92010

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK

Date

9/25/00

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

Man E. N. R. C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME
200 S. HARRISON ST. EASTON, MD 2161023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Cardiogenic Shock*

Due to (or as a consequence of):

b. *ASHD with Atrial fibrillation*

Due to (or as a consequence of):

c. *Congestive Heart Failure*

Due to (or as a consequence of):

d. *1 yr*Approximate
Interval Between
Onset and Death*when*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Recent hip fracture**Recent Acute renal failure & dehydration**Clostridium difficile diarrhea*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William H. Wood, Jr. MD

29c. License number

D08715

29d. Date signed (Month, Day, Year)

9/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM H. WOOD, JR. MD 505 DUTCHMAN'S LANE EASTON, MARYLAND 21601

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

William H. Wood, Jr.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32081

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM CHARLES WILKINS				2. Date of Death Month Day Year SEPT. 25, 2000		3. Time of Death 6:00 PM	
	4a. Facility Name (If not institution, give street and number) 21 S. HANSON STREET				4b. City, Town, or Location of Death EASTON		4c. County of Death TALBOT	
Funeral Director	5. Social Security Number 215-18-4189		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 29, 1918	
	9. Birthplace (State or Foreign Country) MD.							
Usual Residence of Decedent		10a. State MD.		10b. County TALBOT		10c. City, Town or Location EASTON		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 21 S. HANSON STREET		10f. Zip Code 21601		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 06 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry HIGHWAY CONSTRUCTION				
17. Father's Name (First, Middle, Last) HAZEL WILKINS				18. Mother's Name (First, Middle, Maiden Surname) FANNIE JACKSON				
19a. Informant's Name/Relationship (Type, Print) MARGARET JENKINS/SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1665 EASTON, MD. 21601				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RICHARDS MEMORIAL PRK		20c. Date 9/30/00		20d. Location - City or Town, State EASTON, MD.		
21. Signature of Funeral Service Licenses Eric L. Dashiell				22. Name and Address of Facility DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. Cardiac Arrest due to Ventricular Fibrillation Due to (or as a consequence of):		f. Congestive Heart Failure Due to (or as a consequence of):		g. Arteriosclerotic Heart Disease Due to (or as a consequence of):		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		Approximate Interval Between Onset and Death 2 yrs 15 yrs		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus II Severe insufficiency of legs								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William Howard J.		29c. License number 1208715		29d. Date signed (Month, Day, Year) 9/27/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) WILLIAM WOOD, JR. MD 505 DUTCHMANS LANE EASTON, MD. 21601								
31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32082

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard M Wilkins

2. Date of Death

OCT 04 2000

3. Time of Death

10 03 AM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

184-01-0805

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

January 13, 1919 New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7913 Belgaro Road

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tax Information Specialist

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Richard M. Wilkins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Rogers

19a. Informant's Name/Relationship (Type, Print)

Frances Wilkins/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7913 Belgaro Road Laurel, MD 20723

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

10/5/00

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Michael E. Silverman MD1213

22. Name and Address of Facility

313 Talbott Ave.
Donaldson Funeral Home, P.A. Laurel, MD 2070723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. Enter only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Pneumonia
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Parkinson's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Michael E. Silverman MD

29c. License number

D41274

29d. Date signed (Month, Day, Year)

OCT 04 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael E Silverman, MD Howard County Gen Hosp Columbia MD 21044

State
Registrar

31. Date filed (Month, Day, Year)

OCT 06 2000

32. Registrar's Signature

Anna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32083

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine Cecilia Wilhelm

2. Date of Death
Month Day Year
September 17, 20003. Time of Death
06:58 PM

4a. Facility Name (If not institution, give street and number)

Frostburg Village Nursing Care Center

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

213-12-9743

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
08-May-20

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

40 Locust Street

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Anderson James Green

18. Mother's Name (First, Middle, Maiden Surname)

Mary Veronica Monahan

19a. Informant's Name/Relationship (Type, Print)

Patrick D. Wilhelm Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

40 Locust Street Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frostburg Memorial Park

Date

20-Sep-00

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION < ONE HOUR

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE > 5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETE MELLITES

ALZHEIMERS DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D24951

29d. Date signed (Month, Day, Year)

Sept. 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chang-Hyun Oh, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

31. Date filed (Month, Day, Year)

SEP 18 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

SEP 1 8 2000

CHURCH-HOME OF M.D. 40 TOW. TOWNSHIP, MARYLAND 21203

Dust Funerals Home, 57 First Ave., Frostburg, MD 21532

20-26p-00 Frostburg, Maryland

Frostburg, Maryland 21532

Frostburg Memorial Park
47 First Street

Patrick D. Wilhelm 2m

Anderson James Green

Mary Virginia Monahan

Homer Miller

Homer Miller

Wilho

U.S.A.

Frostburg

40 First Street

Maryland

Allegheny

80

215-12-2323

Frostburg Village Nursing Home Center

Frostburg

Allegheny

08-May-20

Maryland

September 7, 2000

08:28 PM

Edna Cecile Wilhelm

Amended # 19a, 9/19/00,
Md., Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32084

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE RAYMOND WERTZ				2. Date of Death Month Day Year SEPTEMBER 17 2000				3. Time of Death 7:13PM	
	4a. Facility Name (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME				4b. City, Town, or Location of Death FROSTBURG				4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 214-07-1228		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 12 1909		9. Birthplace (State or Foreign Country) PA.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1727 BEDFORD STREET				10f. Zip Code 21502				10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER ALLSTATES GROCERY CO.				16b. Kind of Business/Industry GROCERY/WHOLESALE	
	17. Father's Name (First, Middle, Last) WILLIAM WALTER WERTZ				18. Mother's Name (First, Middle, Maiden Surname) EFFIE OSTER					
	19a. Informant's Name/Relationship (Type, Print) PEGGY HUGHES GRANDAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 VOCKE DRIVE LAVALE, MARYLAND 21502					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY SEPT 13 2000				20c. Location - City or Town, State CUMBERLAND MARYLAND			
	21. Signature of Funeral Service Licensee Dale L. Merritt				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerosis</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 10 years									
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u> <u>Dementia</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 10 <u>Dr. George Breza</u>				29c. License number D 12532				29d. Date signed (Month, Day, Year) SEPTEMBER 18, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR GEORGE BREZA 912 SETON DRIVE CUMBERLAND MARYLAND 21502									
	31. Date filed (Month, Day, Year) SEP 19 2000				32. Registrar's Signature <u>George B. Sparks</u>					

and a...

SEP 14 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32085

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Angela Weisenborne				2. Date of Death Month Day Year 09-19-2000		3. Time of Death 3:07 PM		
	4a. Facility Name (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME				4b. City, Town, or Location of Death FROSTBURG		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 216 01 8834	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) APRIL 26 1912		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ALLEGANY	10c. City, Town or Location FROSTBURG			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 23 WASHINGTON STREET			10f. Zip Code 21532		10g. Citizen of What Country? U.S.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES			16b. Kind of Business/Industry VARIETY STORE			
	17. Father's Name (First, Middle, Last) HUGH DONAHUE				18. Mother's Name (First, Middle, Maiden Surname) GERALDINE HUGHES				
	19a. Informant's Name/Relationship (Type, Print) STEPHEN WEISENBORNE / GRANDSON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11435 ROWLEY ROAD, CLARKSVILLE, MD 21029				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MICHAEL'S CEMETERY 9/22/00		20c. Location - City or Town, State FROSTBURG, MD				
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532				
	23a. Part I. Enter life disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) e. Thyroid CARCINOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								5 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophageal Stricture Organic Brain Syndrome.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D25638		29d. Date signed (Month, Day, Year) September 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATURNIA CHANG, M.D. 10761 New George Creek S.W. Suite 3 Frostburg Maryland 21532									
31. Date of Death (Month, Day, Year) SEP 21 2000		32. Registrar's Signature [Signature]							

James H. Jones

1875 / 2 433

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32086

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELEANOR JOSEPHINE WINGERT

2. Date of Death

Month Day Year
9 22 00

3. Time of Death

9:40 AM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

215-20-5713

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 27, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

MT. SAVAGE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14014 MT. SAVAGE ROAD, N.W.

10f. Zip Code

21545

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

REGISTERED NURSE

16b. Kind of Business/Industry

NURSING - HOSPITAL

17. Father's Name (First, Middle, Last)

WILLIAM N. BENNETT

18. Mother's Name (First, Middle, Maiden Surname)

LILY RETZER

19a. Informant's Name/Relationship (Type, Print)

PENNY E. LOGSDON / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1717 BEDFORD STREET, CUMBERLAND, MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

SUNSET MEMORIAL PARK

Date

9/25/2000

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

Dong A. Upchurch

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Methicillin Resistant Staphylococcus aureus sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

10 days

b. Cellulitis

Due to (or as a consequence of):

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Pyoderma gangrenosum

Due to (or as a consequence of):

2 years

d. Rheumatoid arthritis

Due to (or as a consequence of):

30 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

New onset atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident
3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael D. Zang M.D.

29c. License number

D0054426

29d. Date signed (Month, Day, Year)

SEPT. 22 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL D. ZANG M.D. MEM. MED. BLDG. 105, 500 MEM. AVE. CUMB. MD. 21502

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Brent B. Sparks

ELEANOR WINGERT 215-20-5713
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 24a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Sept 8. 1892

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32087

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCIS BURNELL WAGNER		2. Date of Death Month 9 Day 19 Year 2000		3. Time of Death 2120
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 176-05-2490	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JAN. 5, 1921		9. Birthplace (State or Foreign Country) PENNSYLVANIA		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County WICOMICO	10c. City, Town or Location SALISBURY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 1505 LAVALE TERRACE		10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No USMC If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR		16b. Kind of Business/Industry NATIONAL CAN CORP.		
	17. Father's Name (First, Middle, Last) JOHN H. WAGNER		18. Mother's Name (First, Middle, Maiden Surname) ANNA KRITCHEN		
	19a. Informant's Name/Relationship (Type, Print) REBECCA STRAUB		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8229 BELLONA AVE. TOWSON, MD 21204		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERAN'S CEMETERY		20c. Location - City or Town, State 10/9/00 HURLOCK, MARYLAND
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. bladder carcinoma Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal failure prostate cancer					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Rodney A. Wenrich, MD.		29c. License number D15384		29d. Date signed (Month, Day, Year) 9/19/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODNEY A. WENRICH 100 POWER ST. SALISBURY MD 21804					
31. Date filed (Month, Day, Year) SEP 21 2000		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32088

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cecelia C. Wishtart				2. Date of Death Month October Day 1 Year 2000		3. Time of Death 7:25am				
	4a. Facility Name (If not institution, give street and number) St. Agnes Nursing & Rehabilitation Center				4b. City, Town, or Location of Death Ellicott City		4c. County of Death Howard				
Funeral Director	5. Social Security Number 178 01 8701		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 6, 1912				
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Howard		10c. City, Town or Location Columbia				
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 10618 Green Mountain Circle		10f. Zip Code 21044		10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Dress Factory						
	17. Father's Name (First, Middle, Last) Michael Crake				18. Mother's Name (First, Middle, Maiden Surname) Helen unknown						
	19a. Informant's Name/Relationship (Type, Print) Elaine Raksis/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10618 Green Mountain Circle Columbia, MD 21044						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's		20c. Location - City or Town, State 10-4-2000 Wilkes-Barre, PA						
	21. Signature of Funeral Service Licensee Sharon Collins-Witzke		22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043								
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. DEMENTIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. </td> <td colspan="2">Approximate Interval Between Onset and Death 5 MINUTES YEARS</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. DEMENTIA Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 5 MINUTES YEARS	
	Immediate Cause (Final disease or condition resulting in death) e. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. DEMENTIA Due to (or as a consequence of): c. Due to (or as a consequence of): d.	Approximate Interval Between Onset and Death 5 MINUTES YEARS									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier James P. Richardson MD				29c. License number 827394		29d. Date signed (Month, Day, Year) October 1, 2000					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JAMES P. RICHARDSON M.D., 700 GEAR ROAD, CATONSVILLE, MD 21228											
31. Date filed (Month, Day, Year) OCT - 2 2000		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32089

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Elwood WARNICK

2. Date of Death

Month Day Year
Sept. 13, 2000

3. Time of Death

10:10 AM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

217-20-5554

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 30, 1925

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18281 Garrett Highway

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12+

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Paper Production

17. Father's Name (First, Middle, Last)

Henry Leonard Warnick

18. Mother's Name (First, Middle, Maiden Surname)

Ressie ----- Coakley

19a. Informant's Name/Relationship (Type, Print)

Leota B. Warnick/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18281 Garrett Hwy., Oakland, Md. 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Deer Park Cemetery

Date

9/16/00

20c. Location - City or Town, State

Deer Park, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, Md. 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiomyopathy

Approximate Interval Between Onset and Death

Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):c. Due to (or as a consequence of):d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23979

29d. Date signed (Month, Day, Year)

9-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert A. Goralski 311 n. Fourth St., Oakland, Md. 21550

State
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32090

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jin Yim				2. Date of Death Month Day Year Sept. 23, 2000				3. Time of Death 9:10am											
	4a. Facility Name (If not institution, give street and number) 2204 Bear Valley Terrace				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery											
Funeral Director	5. Social Security Number 058-70-1303		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) May 28, 1930		9. Birthplace (State or Foreign Country) China											
	Usual Residence of Decedent																			
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
10e. Street and Number 2204 Bear Valley Terrace				10f. Zip Code 20906		10g. Citizen of What Country? USA														
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Asian												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Forman				16b. Kind of Business/Industry Manufacturing/Plastics												
17. Father's Name (First, Middle, Last) Chee Lun Yim				18. Mother's Name (First, Middle, Maiden Surname) Wan Hine Chi																
19a. Informant's Name/Relationship (Type, Print) Mattan Yim / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Bear Valley Terrace, Silver Spring, MD 20906																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date 09/28/00		20d. Location - City or Town, State Silver Spring, Maryland														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Colon Cancer</td> <td rowspan="4"> Due to (or as a consequence of): </td> <td rowspan="4"> Approximate Interval Between Onset and Death 3 years </td> </tr> <tr><td>b.</td><td></td></tr> <tr><td>c.</td><td></td></tr> <tr><td>d.</td><td></td></tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Colon Cancer	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 years	b.		c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Colon Cancer	Due to (or as a consequence of):	Approximate Interval Between Onset and Death 3 years																
	b.																			
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred												
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier 				29c. License number D 0052457		29d. Date signed (Month, Day, Year) September 26, 2000														
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Mo Chow, M.D. 9001 Shady Grove Court, Gaithersburg, Maryland 20878																				
31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32091

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS EALER YOUNG

2. Date of Death
Month Day Year
Sept 25 20003. Time of Death
2202Funeral
Director

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

5. Social Security Number

219-82-0906

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 22, 1917

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

ST. MICHAELS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

402 WATER ST.

10f. Zip Code

21663

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

OWNER/OPERATOR

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

EUGENE NICHOLAS

18. Mother's Name (First, Middle, Maiden Surname)

LYDIA EALER

19a. Informant's Name/Relationship (Type, Print)

SHARON YOUNG/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO BOX 96 ST. MICHAELS, MD 21663

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

OXFORD CEMETERY

Date

9-29-00

20c. Location - City or Town, State

OXFORD, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Severe Chronic Obstructive Pulmonary Disease

2 hours

Due to (or as a consequence of):

b. Asthma Exacerbation

2 hours

Due to (or as a consequence of):

Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diastolic Heart Dysfunction

Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Staff Physician

29c. License number

DS0328

29d. Date signed (Month, Day, Year)

Sept 26, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES F. ELMORE, M.D. 219 S. WASHINGTON ST EASTON MD 21601

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

[Signature] B. SparksState
RegistrarGladys Young
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32092

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SUSAN VIRGINIA ZIRK				2. Date of Death Month Day Year SEPT. 16, 2000				3. Time of Death 10:45 PM	
	4e. Facility Name (If not institution, give street and number) ALLEGANY COUNTY NURSING HOME				4b. City, Town, or Location of Death CUMBERLAND				4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 234-36-2717		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) OCT. 29, 1914		9. Birthplace (State or Foreign Country) WEST VIRGINIA		10a. State WV		10b. County MINERAL		10c. City, Town or Location RIDGELEY	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number ROUTE 2, BOX 300		10f. Zip Code 26753		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) YARN INSPECTOR		16b. Kind of Business/Industry CELANESE FIBERS CORPORATION						
17. Father's Name (First, Middle, Last) JOHN WILLIAM EVANS				18. Mother's Name (First, Middle, Maiden Surname) ANNA LORRIANE CORBIN						
19a. Informant's Name/Relationship (Type, Print) ARNOLD E. ZIRK / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 614, RIDGELEY, WV 26753						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. LUKE'S PRESBYTERIAN CH.CEM.		Date 9/19/2000		20c. Location - City or Town, State GLEBE, WV				
21. Signature of Funeral Service Licensee <i>Shirley D. Upchurch</i>				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC RENAL FAILURE Due to (or as a consequence of): b. ARTERIOSCLEROTIC CARDIOVASCULAR HEART DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death MONTHS								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Paul Snow</i>		29c. License number D09157		29d. Date signed (Month, Day, Year) SEPT. 17, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D. - 124 W. Third Street, Cumberland, MD 21502		31. Date filed (Month, Day, Year) SEP 20 2000		32. Registrar's Signature <i>James B. Sparks</i>						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202.58.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 2 of 2

SEP 10 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32093

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIAN MIDDLETON ZEMBOWER

2. Date of Death

Month Day Year
SEPTEMBER 19 2000

3. Time of Death

7:30 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

13711 JOHN CLINE ROAD

4b. City, Town, or Location of Death

SMITHSBURG

4c. County of Death

WASHINGTON

5. Social Security Number

217-10-1708

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
DEC 27 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WASHINGTON

10c. City, Town or Location

SMITHSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13711 JOHN CLINE ROAD

10f. Zip Code

21783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NATIONAL SECURITY AGENCY

16b. Kind of Business/Industry

STATISTICIAN

17. Father's Name (First, Middle, Last)

CHARLES M. HENDRICKSON

18. Mother's Name (First, Middle, Maiden Surname)

ROSALIE MIDDLETON

19a. Informant's Name/Relationship (Type, Print)

DARYL ZEMBOWER

SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4993 EVITTS CREEK ROAD BEDFORD PA. 15522

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PLEASANT GROVE CEMETERY SEPT 22 2000 CUMBERLAND MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME P.A.
404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

YEARS

Due to (or as a consequence of):

b. MITRAL INSUFFICIENCY

YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Sherman Kahan MD

29c. License number

D12697

29d. Date signed (Month, Day, Year)

9/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Sherman Kahan 915 Tollhouse Ave #307 Frederick, MD 21701

31. Date (Month, Day, Year)

SEP 21 2000

32. Registrar's Signature

[Signature]

State
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Zembower, Marian 9/19/00
Baltimore, Maryland 21215-0020



Handwritten text, possibly a date or reference number, oriented vertically along the right edge.

Handwritten signature or initials at the bottom center of the page.

266 S. 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32094

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK ABRAMOUKCY				2. Date of Death Month Day Year OCTOBER 3 2000		3. Time of Death 1900	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTH CARE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 214-16-6987		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Jan 20, 1914	
	9. Birthplace (State or Foreign Country) Poland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 55 Wade Avenue		10f. Zip Code 21228		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) disabled		16b. Kind of Business/Industry none			
	17. Father's Name (First, Middle, Last) Vincent Abrams				18. Mother's Name (First, Middle, Maiden Surname) Anna Souvers			
	19a. Informant's Name/Relationship (Type, Print) St. Agnes Hospital				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD 21229			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. ANOXIC ENCEPHALOPATHY Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MEDICAL RESIDENT				29c. License number P13604		29d. Date signed (Month, Day, Year) OCTOBER 03, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD OFFER ADDO, 900 CATON AVENUE, BALTIMORE, MD 21229								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature						

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME ABRAMS, FRANK J.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

42-32

11
12
13
14
15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32095

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Allen H. Ashby				2. Date of Death Month Day Year Oct. 06, 2000		3. Time of Death 2:00am	
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care Homewood				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 214-20-7655		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 04-17-25	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				10a. State MD		10b. County NA	
To Be Completed by Funeral Director	10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 2707 Kirk Avenue				10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Dupont company			
	17. Father's Name (First, Middle, Last) Allen Ashby				18. Mother's Name (First, Middle, Maiden Surname) Estelle Ashby			
	19a. Informant's Name/Relationship (Type, Print) Bernice Ashby				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2707 Kirk Avenue Baltimore, Maryland 21218			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem.		20c. Location - City or Town, State 10-11-2000 Arbutus, MD			
	21. Signature of Funeral Service Licensee Bernard D. Johnson				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostate CA Due to (or as a consequence of): b. Colon CA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia senile, obstructive uropathy s/p cholecystomy s/p nephrectomy - ductotomy								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Martha C. Raymond MD				29c. License number D5 4518		29d. Date signed (Month, Day, Year) 10-9-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3007 2 Northern Parkway Baltimore MD 21214 MARTHA C. RAYMOND								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature Benjamin B. Sparks				

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#17 per FHG788 10/18/2000 E State of Maryland / Department of Health and Mental Hygiene 00 32096
Amended Item#20b per FHG788 10/12/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Rathleen M. Bory</u>		2. Date of Death Month <u>October</u> Day <u>11</u> Year <u>2000</u>		3. Time of Death <u>02:12am</u>
	4a. Facility Name (If not institution, give street and number) <u>Mercy Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>City</u>
Funeral Director	5. Social Security Number <u>031-16-2707</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>75</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>Nov. 29 1924</u>		9. Birthplace (State or Foreign Country) <u>Mass.</u>		
Usual Residence of Decedent					
10a. State <u>Md.</u>		10b. County <u>n/a</u>		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>1530 Riverside Ave.</u>			10f. Zip Code <u>21230</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>white</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u>0</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housewife</u>		16b. Kind of Business/Industry <u>Home Owner</u>
17. Father's Name (First, Middle, Last) <u>Wright A. Edmundson Edmundson</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Mary F. McKenna</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Francis L. Bory (Husband)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1530 Riverside Ave. Baltimore, MD. 21230</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Green Mount Cemetery 10/11/2000</u>		20c. Location - City or Town, State <u>Baltimore, Md.</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>			22. Name and Address of Facility <u>McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230</u>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		e. <u>Neutropenic Septic Shock</u>			Approximate Interval Between Onset and Death <u>24 hours</u>
		Due to (or as a consequence of):			
		b. <u>Ovarian cancer</u>			<u>4 months</u>
		Due to (or as a consequence of):			
		c.			
		Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D40744</u>		29d. Date signed (Month, Day, Year) <u>October 11, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>K.A. Karzick, MD Mercy Hospital 301 St Paul St, Baltimore MD 21202</u>					
31. Date filed (Month, Day, Year) <u>OCT 12 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

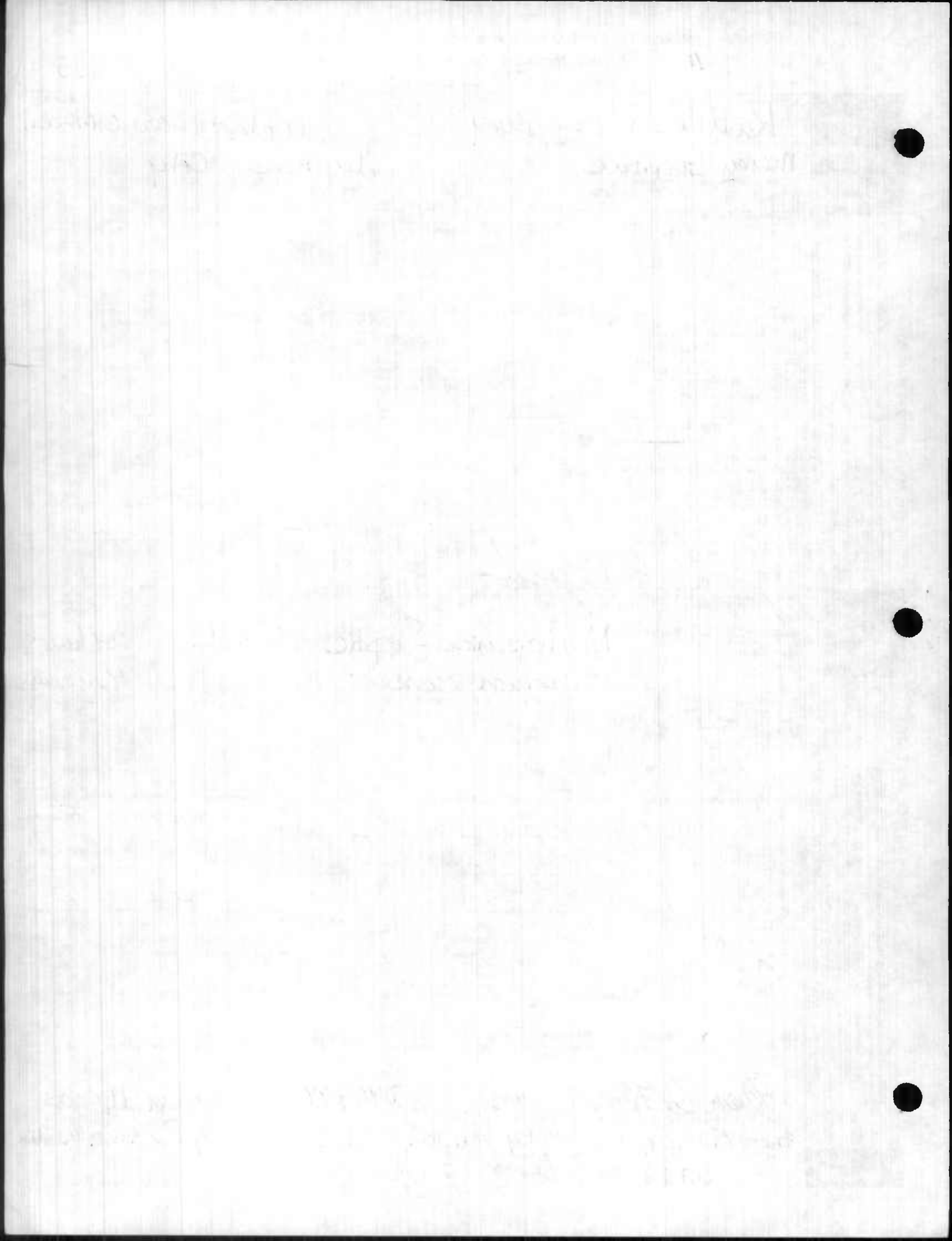
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32097

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE BLUM		2. Date of Death Month 10 Day 4 Year 2000		3. Time of Death 6 45 PM
	4a. Facility Name (If not institution, give street and number) Bon Secours Balto Health System Balto.		4b. City, Town, or Location of Death Balto.		4c. County of Death Balto.
Funeral Director	5. Social Security Number 219-07-6789	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Apr 8, 1921		9. Birthplace (State or Foreign Country) MD		
Usual Residence of Decedent					
10a. State MD		10b. County		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2095 Rockrose Avenue		10f. Zip Code 21211	
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) steelworker		16b. Kind of Business/Industry unk			
17. Father's Name (First, Middle, Last) unk			18. Mother's Name (First, Middle, Maiden Surname) unk		
19a. Informant's Name/Relationship (Type, Print) Bon Secours Hospital			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 W. Baltimore Street Baltimore, MD 21223		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Schizophrenia Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier Andr Ubeeri		29c. License number D26748		29d. Date signed (Month, Day, Year) 10/7/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andr Ubeeri MD 4419 Falls Road Balto MD 21211					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Benjamin B. Spotts			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32098

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred J. Bates				2. Date of Death Month Day Year OCTOBER 9, 2000		3. Time of Death 7:15 AM		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 235-40-3138		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-17-1926	9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent								
10a. State MD.		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 7656 3rd. Ave.				10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home			
17. Father's Name (First, Middle, Last) Marvin Lane					18. Mother's Name (First, Middle, Maiden Surname) Nettie Goldsmith				
19a. Informant's Name/Relationship (Type, Print) Doris Bates (Daughter)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5284 Randolph Rd. #146 Rockville, MD. 20852-2116				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Pk.		20c. Location - City or Town, State 10-12-00 Glen Burnie, MD.		20d. Date		
21. Signature of Funeral Service Licensee <i>Richard Pickett</i>					22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finest disease or condition resulting in death) e. PNEUMONIA Due to (or as a consequence of): b. CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier <i>MD</i>	
29c. License number DS1245								29d. Date signed (Month, Day, Year) OCTOBER 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAJID SHARIF NORTH ARUNDEL HOSPITAL GLEN BURNIE MD 21060									
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature <i>Denise B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32099

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN E. BROHAWN

2. Date of Death

Month Day Year
09 29 00

3. Time of Death

12:08AM

4a. Facility Name (If not institution, give street and number)

Hill Haven Nursing Home

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince Georges'

Funeral
Director

5. Social Security Number

218-05-9682

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
October 20, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

524 North Charles Street

10f. Zip Code

21201

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Shift Supervisor

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Irving Brohawn

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Dames

19a. Informant's Name/Relationship (Type, Print)

Carol Brohawn/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18230 Fox Chase Circle, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Date

10-1-00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Lisa S. Jefferson

22. Name and Address of Facility

Loudon Park Funeral Home
3620 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jennifer B. Sparks

29c. License number

D25009

29d. Date signed (Month, Day, Year)

October 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11251 Lockwood Drive, Silver Spring, Maryland 20901

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Jennifer B. Sparks

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32100

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) E DNA BROWN				2. Date of Death Month OCTOBER Day 8th Year 2000		3. Time of Death 9:00 PM	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 214-40-5660		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) 05-09-11	
	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Master				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Baltimore Public School System		
17. Father's Name (First, Middle, Last) Daniel C. Brown				18. Mother's Name (First, Middle, Maiden Surname) Katie Johnson				
19a. Informant's Name/Relationship (Type, Print) Olga E. Ellis				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4717 Charlton Avenue Baltimore, Maryland 21214				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 10-11-2000		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Gladys Wane				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE Due to (or as a consequence of): HYPERTENSION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PULMONARY HYPERTENSION Due to (or as a consequence of): Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY HYPERTENSION						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes <input type="checkbox"/> No		
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Wulany Nunez				29c. License number P13457		29d. Date signed (Month, Day, Year) October 8th 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSEMARIE MARR 40 GOOD SAMARITAN HOSPITAL 5601 LOCH LANE BALT 21239								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature Benita B. Sparks				

11

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32101

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Jennie Lee Buck		2. Date of Death Month October Day 08 Year 2000		3. Time of Death 1924pm			
4a. Facility Name (If not institution, give street and number) 14 Rambling Oak Way, Apartment B			4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore		
5. Social Security Number 213-68-5774		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) OCT 20, 1956	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 513 Valcour Road		10f. Zip Code 21228		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Social Security Administration			
17. Father's Name (First, Middle, Last) Donald G. Reichlin			18. Mother's Name (First, Middle, Maiden Surname) Evelyn Helen Brady				
19a. Informant's Name/Relationship (Type, Print) Donald G. Reichlin/Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14-B Rambling Oaks Way Catonsville, MD 21228				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 10-10-00 Baltimore, MD			
21. Signature of Funeral Service Licentiate Edward A. Gregorchik		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. EPHEDRINE INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) found: 10/8/00		28b. Time of Injury (P M) found: 7:05		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred unknown		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found: Apartment		28f. Location (Street and Number or Rural Route Number, City or Town, State) 14 Rambling Oaks Way Catonsville, MD.	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Maureen Dore Shule	
29c. License number O.C.M.E.						29d. Date signed (Month, Day, Year) October 09, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYANN A. KOREN MD 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Bernard A. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32102

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel T. Bittle

2. Date of Death
Month Day Year

October 9 2000 5:30 PM

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

481-10-3507

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

MAR 29, 1913

9. Birthplace (State or Foreign Country)

Iowa

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Glen Arm

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11630 Glen Arm Road

10f. Zip Code

21057

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Federal Employee

17. Father's Name (First, Middle, Last)

Jason Teter

18. Mother's Name (First, Middle, Maiden Surname)

Jesse Sohner

19a. Informant's Name/Relationship (Type, Print)

Anna W. Bittle/Sister-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13943 Jarrettville Pike Phoenix, MD 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc.

Data

10-10-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorich

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

10/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

B. Sparks

October 9, 2000 5:30 p.m.
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Hazel Bittle

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32103

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances Bradford				2. Date of Death Month: 10 Day: 9 Year: 2000				3. Time of Death 6: 40 p.m.				
	4a. Facility Name (If not institution, give street and number) 431 Notre Dame Lane Apt 307				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A				
Funeral Director	5. Social Security Number 220-20-8290		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) 1-5-1929		9. Birthplace (State or Foreign Country) Md				
	Usual Residence of Decedent				10a. State Md				10b. County N/A		10c. City, Town or Location Baltimore		
To Be Completed by Funeral Director	10e. Street and Number 431 Notre Dame Lane Apt 307				10f. Zip Code 21212				10g. Citizen of What Country? U S A				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Person				16b. Kind of Business/Industry Lerner Shop				
	17. Father's Name (First, Middle, Last) David Booze				18. Mother's Name (First, Middle, Maiden Surname) Edna Dillen								
	19a. Informant's Name/Relationship (Type, Print) Patrick Merrick- Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4004 Bowers Avenue Baltimore, Md 21207								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veteran				20c. Location - City or Town, State 10-13-00 Owings Mills, Md				
	21. Signature of Funeral Service Licensee <i>John B. Johnson</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Myocardial infarction Due to (or as a consequence of): b. uncontrolled diabetes Due to (or as a consequence of): c. uncontrolled hypercholesterolemia Due to (or as a consequence of): d. hyperbromism				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Schizophrenia				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>S. Abate MD</i>				29c. License number DS0296					
29d. Date signed (Month, Day, Year) 10/11/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHASTINE ABATE 4 West gallery Rd Catonsville MD				31. Date filed (Month, Day, Year) OCT 12 2000					
32. Registrar's Signature <i>Sparks</i>				31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature <i>Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK ROBERT BACHMANN JR.				2. DATE OF DEATH MONTH SEPT DAY 13 YEAR 2000		3. TIME OF DEATH 2:00 P.M.	
4. SOCIAL SECURITY NUMBER NONE		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 0 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-13-2000	
8a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				8b. CITY, TOWN OR LOCATION OF DEATH TOWSON		8c. COUNTY OF DEATH Baltimore	
10a. STATE MD		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9903 Dehavilland Way apt c				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) FRANK ROBERT BACHMANN Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kelly A. Roach			
19a. INFORMANT'S NAME (Type/Print) FRANK Bachmann - Father				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9903 Dehavilland Way apt c BALTO MD 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SCHWARTZ CEMETERY		20c. DATE 9/18/00		20d. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAVID WEBER (PER D.V.R.)				22. NAME AND ADDRESS OF FACILITY DAVID WEBER FUNERAL HOMES P.A. 401 S. CHESTER STREET BALTIMORE, MARYLAND 21231			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PERINATAL ASPHYXIA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 30 min	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PRE TERM PREGNANCY 34 wks Poorly controlled gestational D.m DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jeffrey Pomarance M.D.				29c. LICENSE NUMBER D0051676		29d. DATE SIGNED (Month, Day, Year) 9/21/00	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY POMARANACE 6701 NORTH CHARLES STREET TOWSON, MARYLAND 21204							
31. DATE FILED (Month, Day, Year) OCT 12 2000		32. REGISTRAR'S SIGNATURE Sparks					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32105

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NANCY LEE BALL				2. Date of Death Month Day Year OCTOBER 6, 2000				3. Time of Death 11:31am			
	4a. Facility Name (If not institution, give street and number) 9 S. MONASTERY AVE.				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A			
Funeral Director	5. Social Security Number 251-38-9422		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 6-24-1926		9. Birthplace (State or Foreign Country) SC			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 9 S. MONASTERY AVE.				10f. Zip Code 21229				10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (14 or 5+) -2-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING ASSISTANT				16b. Kind of Business/Industry HEALTHCARE			
	17. Father's Name (First, Middle, Last) WADE BUCKSON SR.				18. Mother's Name (First, Middle, Maiden Surname) RACHELE KINSLER							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) IRITA PACK (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 N. WOODINGTON RD. BALTIMORE, MARYLAND 21229							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR ROCK BAPT. CHURCH		20c. Location - City or Town, State 10-12-2000 CHESTER, SC							
	21. Signature of Funeral Service Licensed 				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number D37343		29d. Date signed (Month, Day, Year) 10-9-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATHOL MORGAN MD., 2600 LIBERTY HEIGHTS AVE. BALTIMORE, MARYLAND 21215												
State Registrar	31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32106

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY E. BANKS

2. Date of Death
Month Day Year
OCTOBER 8, 20003. Time of Death
5:30am

4a. Facility Name (If not institution, give street and number)

LEVINDALE NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

219-30-9834

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10-28-1920

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3325 W. GARRISON AVE.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
-12-College (14 or 5+)
-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEKEEPING

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

RICHARD BANKS

18. Mother's Name (First, Middle, Maiden Surname)

EMMA BEALE

19a. Informant's Name/Relationship (Type, Print)

MURIEL ARMSTEAD(SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3325 W. GARRISON AVE. BALTIMORE, MARYLAND 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. CALVARY CEMETERY

Date

10-14-2000 GLEN BURNIE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jonathan D. Hulse

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.
1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Coronary Thrombosis*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Raymond Miller

29c. License number

D47683

29d. Date signed (Month, Day, Year)

10/10/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Raymond Miller 25 Main Street Suite 200 Rockolawn MD

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Barbara B Sparks

State Registrar

ORIGINAL

Dorothy Banks
Baltimore, Maryland 21215-2020Division of Vital Records P.O. Box 68760,
Baltimore, Maryland 21215-2020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

A/H

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32107

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Mae Barton				2. Date of Death Month Oct. Day 11, Year 2000		3. Time of Death 12:15 am	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Heritage				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 226-16-5400		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 1, 1921	
	9. Birthplace (State or Foreign Country) Va.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7589 Ives Lane Apt A		10f. Zip Code 21222	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 yrs. College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Walter Barbour				18. Mother's Name (First, Middle, Maiden Surname) Elise Durham			
	19a. Informant's Name/Relationship (Type, Print) Carolyn Vitek Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7589 Ives Lane Apt A. Dundalk, Md. 21222			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory		20c. Location - City or Town, State Oct 11, 2000 Baltimore City	
	21. Signature of Funeral Service Licensee <i>Anthony Connelly</i>				22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222			
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Carcinoma of Lung Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): 3 years 20 years				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes Mellitus				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <i>Harjit Singh M.D.</i>				29c. License number D0014160		29d. Date signed (Month, Day, Year) 10/11/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature <i>Sparks</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32108

Amended Item#8 per FHG788 10/30/2000 EW

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest B. Carter

2. Date of Death

October 10, 2000 9:16 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GIEN BURNIE

4c. County of Death

AA County

5. Social Security Number

226-10-2378

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 9, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7959 Telegraph Road Lot 142

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 42-'4513. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
7

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Civil Service

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Woody W. Carter

18. Mother's Name (First, Middle, Maiden Surname)

Claude G. Frost

19a. Informant's Name/Relationship (Type, Print)

Ernest M. Carter / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11028 Thrush Ridge Road Reston, Virginia 20191

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lakemont Mem. Gardens

Date

Oct. 14,
2000

20c. Location - City or Town, State

Davidsonville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION 2 HRS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. ARTERIOSCLEROTIC CARDIOVASCULAR
DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 21776

29d. Date signed (Month, Day, Year)

OCTOBER 11, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SUREA MUMBARA MD 3001 S. HANOVER ST BALTIMORE 21225

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

S. HANOVER ST BALTIMORE 21225

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32109

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice Pauline Crolius

2. Date of Death

Month Day Year
Oct. 10, 2000

3. Time of Death

3:20 p.m.

4a. Facility Name (If not institution, give street and number)

9010 Briarcroft Lane

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George

Funeral
Director

5. Social Security Number

140-03-8282

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 17, 1913

9. Birthplace (State or Foreign Country)

Vermont

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9010 Briarcroft Lane

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Assistant

16b. Kind of Business/Industry

Pharmacy

17. Father's Name (First, Middle, Last)

Lewis Geiger

18. Mother's Name (First, Middle, Maiden Surname)

Phoebe Lambert

19a. Informant's Name/Relationship (Type, Print)

Valerie Geiger/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4658 Dower Drive, Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Columbia memorial

Date

10/13/00

20c. Location - City or Town, State

Columbia, Maryland

21. Signature of Funeral Service Licensee

► *Sandra Schen*

22. Name and Address of Facility

Fleck Funeral Home, Inc.

7601 Sandy Spring Road, Laurel, Maryland 20707

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

PANCREATIC CANCER

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

~ 2 months

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 3 ☐ Suicide
4 ☐ Homicide 6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► *Schelle*

29c. License number

D45014

29d. Date signed (Month, Day, Year)

October 11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISABELLA MARTINE NO 8379 CHERRY LANE LAUREL MD 20707

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

► *Sparks*State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

amend item 23a,27,28a,b,c,d,e,f per me G788 10/23/00 yf **Certificate of Death**

Reg. No.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-386-6060.

Physician /Medical Examiner

Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last)
Mark Allen Collins

2. Date of Death
Month Day Year
OCTOBER 10, 2000

3. Time of Death
1938 PM

4a. Facility Name (If not institution, give street and number)
8229 FOREST GLEN DRIVE

4b. City, Town, or Location of Death
PASADENA

4c. County of Death
ANNE ARUNDEL

5. Social Security Number
212-90-5040

6. Sex
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)
34 Yrs.

8. Date of Birth (Month, Day, Year)
Sept. 2, 1966

9. Birthplace (State or Foreign Country)
Maryland

Usual Residence of Decedent

10a. State
Md.

10b. County
Anne Arundel

10c. City, Town or Location
Pasadena

10d. Inside City Limits
1 ☐ Yes 2 ☒ No

10e. Street and Number
8229 Forest Glen Drive

10f. Zip Code
21122

10g. Citizen of What Country?
U.S.A.

11. Marital Status
1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 10th
College (1-4 or 5+) 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Boiler Maker

16b. Kind of Business/Industry
Union Local

17. Father's Name (First, Middle, Last)
Charles David Collins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)
Joan Sosnowski

19a. Informant's Name/Relationship (Type, Print)
Joan Roberts (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3233 Tartarian Court Baltimore, Maryland 21227

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Green Mount Cemetery

20c. Location - City or Town, State
10/14/00 Baltimore, Maryland

21. Signature of Funeral Service Licensee
[Signature]

22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Avenue Baltimore, Maryland 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death
1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☒ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)
found: 10/10/00

28b. Time of Injury
unknown M

28c. Injury at Work?
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred
unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
home

28f. Location (Street and Number or Rural Route Number, City or Town, State)
8229 Forest Glenn Dr., Pasadena, MD.

29a. Certifier
(Check only one)
1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
[Signature]

29c. License number
OCME

29d. Date signed (Month, Day, Year)
OCTOBER 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LARON LOCKE, MD

31. Date filed (Month, Day, Year)
OCT 12 2000

32. Registrar's Signature
[Signature]

111 Penn Street, Baltimore, Maryland 21201

Brenda Elaine Campbell

amend item 23a, pt II, 27 per me G790 12/19/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32111

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Brenda E. Campbell		2. Date of Death Month Day Year October 09, 2000		3. Time of Death 4:59 A.M.	
4a. Facility Name (If not institution, give street and number) 8607 Woodville Road		4b. City, Town, or Location of Death Mount Airy		4c. County of Death Frederick	
5. Social Security Number 217-52-8107	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 30, 1949
9. Birthplace (State or Foreign Country) Virginia		Usual Residence of Decedent			
10a. State Maryland	10b. County Frederick	10c. City, Town or Location Mt. Airy		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8607 Woodville Road		10f. Zip Code 21771		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) 4 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse	
16b. Kind of Business/Industry Health Care Provider		17. Father's Name (First, Middle, Last) Henry Campbell		18. Mother's Name (First, Middle, Maiden Surname) Eunice Hawkins	
19a. Informant's Name/Relationship (Type, Print) Mr. Gary D. Campbell (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8607 Woodville Road Mt. Airy, Maryland 21771			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State 10/13/2000 Towson, Maryland	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROBABLE SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Stephen S. Radentz, M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 10, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Brenda B. Sparks			

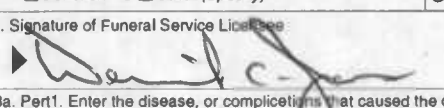
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32112

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Philmore Corbin				2. Date of Death Month Day Year Oct. 11 2000		3. Time of Death 5:40 A.M.	
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care				4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-22-3260		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 07/22/1928	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 501 Dolphin Street Apt. 1304				10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1/7/49		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baker			16b. Kind of Business/Industry Bakery	
17. Father's Name (First, Middle, Last) William Corbin				18. Mother's Name (First, Middle, Maiden Surname) Viola Campbell				
19a. Informant's Name/Relationship (Type, Print) Nimat M. Abdul-Salaam / Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3058 Ascension St., Baltimore, Maryland 21225				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Ceme.		20c. Location - City or Town, State 10/17/00 Owings Mills, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215				
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line. Metastatic Prostate Cancer								Approximate Interval Between Onset and Death 5 years
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  Attending Physician		29c. License number D53642		29d. Date signed (Month, Day, Year) Oct. 12 2000
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) X/D07H00 3007 E Northern Parkway Baltimore 2124K								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 3, 1862. The letter is signed by Abraham Lincoln and is addressed to the Senate and House of Representatives. The letter discusses the state of the Union and the progress of the war against the Confederacy. It also mentions the Emancipation Proclamation and the importance of the Union's victory.

2. The second part of the document is a report from the Secretary of the War Department, dated January 10, 1862. The report is signed by Edwin M. Stanton and is addressed to the President. The report discusses the military situation in the South and the progress of the Union's army. It also mentions the importance of the Union's victory and the need for more resources.

3. The third part of the document is a report from the Secretary of the Navy Department, dated January 15, 1862. The report is signed by Gideon Welles and is addressed to the President. The report discusses the state of the Navy and the progress of the Union's fleet. It also mentions the importance of the Union's victory and the need for more resources.

4. The fourth part of the document is a report from the Secretary of the Treasury Department, dated January 20, 1862. The report is signed by Salmon P. Chase and is addressed to the President. The report discusses the state of the Treasury and the progress of the Union's finances. It also mentions the importance of the Union's victory and the need for more resources.

5. The fifth part of the document is a report from the Secretary of the Interior Department, dated January 25, 1862. The report is signed by Caleb B. Smith and is addressed to the President. The report discusses the state of the Interior and the progress of the Union's land policy. It also mentions the importance of the Union's victory and the need for more resources.

6. The sixth part of the document is a report from the Secretary of the War Department, dated February 1, 1862. The report is signed by Edwin M. Stanton and is addressed to the President. The report discusses the military situation in the South and the progress of the Union's army. It also mentions the importance of the Union's victory and the need for more resources.

7. The seventh part of the document is a report from the Secretary of the Navy Department, dated February 5, 1862. The report is signed by Gideon Welles and is addressed to the President. The report discusses the state of the Navy and the progress of the Union's fleet. It also mentions the importance of the Union's victory and the need for more resources.

8. The eighth part of the document is a report from the Secretary of the Treasury Department, dated February 10, 1862. The report is signed by Salmon P. Chase and is addressed to the President. The report discusses the state of the Treasury and the progress of the Union's finances. It also mentions the importance of the Union's victory and the need for more resources.

9. The ninth part of the document is a report from the Secretary of the Interior Department, dated February 15, 1862. The report is signed by Caleb B. Smith and is addressed to the President. The report discusses the state of the Interior and the progress of the Union's land policy. It also mentions the importance of the Union's victory and the need for more resources.

10. The tenth part of the document is a report from the Secretary of the War Department, dated February 20, 1862. The report is signed by Edwin M. Stanton and is addressed to the President. The report discusses the military situation in the South and the progress of the Union's army. It also mentions the importance of the Union's victory and the need for more resources.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32113

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward J. Dawson				2. Date of Death Month October Day 9 Year 2000		3. Time of Death 2359								
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore City								
Funeral Director	5. Social Security Number 232-60-5687	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jun 12, 1938	9. Birthplace (State or Foreign Country) West Virginia								
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State Virginia	10b. County Frederick County	10c. City, Town or Location Winchester			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number 709 Back Mountain Road			10f. Zip Code 22602		10g. Citizen of What Country? U.S.A.									
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meatcutter		16b. Kind of Business/Industry Grocery										
	17. Father's Name (First, Middle, Last) Not Known			18. Mother's Name (First, Middle, Maiden Surname) Geraldine June Dawson											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joyce A. Dawson			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Back Mountain Road Winchester, Virginia 22602											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Queens Meadow Point Cemetery		20c. Location - City or Town, State Keyser, West Virginia										
	21. Signature of Funeral Service Licensee [Signature] MON13		22. Name and Address of Facility Jones Funeral Home, Inc. 228 S. Pleasant Valley Road Winchester, Virginia 22601												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myelofibrosis Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 7 years</td> </tr> <tr> <td>b. Chronic Lymphocytic Leukemia Due to (or as a consequence of):</td> <td>17 years</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. Myelofibrosis Due to (or as a consequence of):	Approximate Interval Between Onset and Death 7 years	b. Chronic Lymphocytic Leukemia Due to (or as a consequence of):	17 years	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. Myelofibrosis Due to (or as a consequence of):	Approximate Interval Between Onset and Death 7 years													
	b. Chronic Lymphocytic Leukemia Due to (or as a consequence of):	17 years													
	c. _____ Due to (or as a consequence of):														
	d. _____ Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
		28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier Traci Thompson MD				29c. License number RES-000		29d. Date signed (Month, Day, Year) October 10, 2000									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Traci Thompson Johns Hopkins Oncology, Baltimore, Maryland															
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature [Signature]													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32114

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>ROSEMAN</u>		2. Date of Death Month <u>October</u> Day <u>62</u> Year <u>2000</u>		3. Time of Death <u>3:54 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death	
Funeral Director	5. Social Security Number <u>236-70-7411</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>72</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Feb 17, 1928</u>
	9. Birthplace (State or Foreign Country) <u>WV</u>					
Usual Residence of Decedent						
10a. State <u>MD</u>		10b. County		10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <u>3317 Westerward Avenue</u>				10f. Zip Code <u>21218</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>white</u>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u>		College (1-4 or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>body work</u>		16b. Kind of Business/Industry <u>automotive</u>
17. Father's Name (First, Middle, Last) <u>George H. Spears</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Alieha Flowers</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Alice Hendrix/sister</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3317 Westerward Ave Baltimore, MD 21218</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <u>in state</u>		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <u>Ronald S. Wade, Director</u>				22. Name and Address of Facility <u>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</u>		
23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. <u>PNEUMONIA</u> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <u>Days</u>
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u> <u>CORONARY ARTERY DISEASE</u> <u>DEMENTIA</u>						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <u>Roseman</u>				29c. License number <u>628684</u>		29d. Date signed (Month, Day, Year) <u>10/04/00</u>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Edward S. Bestman Johns Hopkins Bayview Balto 21224</u>						
31. Date filed (Month, Day, Year) <u>OCT 12 2000</u>		32. Registrar's Signature <u>Benjamin A. Sparks</u>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32115

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD DIPIETRO

2. Date of Death

10 / 05 / 2000

3. Time of Death

10:10 PM

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral
Director

5. Social Security Number

212-30-8976

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 25, 1935

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

11020 Hidden Fox Court

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1953
1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Manager

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Primo DiPietro

18. Mother's Name (First, Middle, Maiden Summa)

Helen Rose Capo

19a. Informant's Name/Relationship (Type, Print)

Ms. Marilyn L. DiPietro

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11020 Hidden Fox Court Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Columbia Memorial Park

Date

10/10/00

20c. Location - City or Town, State

Clarksville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Approximate Interval Between Onset and Death

10 DAYS

Due to (or as a consequence of):

b. INTESTINAL ILEUS

10 DAYS

Due to (or as a consequence of):

c. COLON CARCINOMA

1 YEAR

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature] MD

29c. License number

D29909

29d. Date signed (Month, Day, Year)

10/06/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCOTT MAVERER MD 2465 RT. 97 SUITE 10 GLENWOOD MD 21738

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32116

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
(Medical
Examiner)Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Chester Durm		2. Date of Death Month October Day 8 Year 2000		3. Time of Death 8:30 PM	
4a. Facility Name (If not institution, give street and number) Harbor Hospital Center		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 219-32-7055	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) 04/30/1933
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland			
10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2779 Yarnall Road		10f. Zip Code 21227		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 2/16/53		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic	
17. Father's Name (First, Middle, Last) Chester Lawrence Durm, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Virginia Daughty Howard			
19a. Informant's Name/Relationship (Type, Print) Cora Lorraine Durm		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2779 Yarnall Rd. Baltimore, MD. 21227			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Brooklyn Park, MD.	
21. Signature of Funeral Service Licensee John D. Baker		22. Name and Address of Facility Ambrose Funeral Home, INC. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squamous Cell Carcinoma of Lung Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease Arteriosclerotic Cardiovascular Disease					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier George Vallecillo		29c. License number 026203	
29d. Date signed (Month, Day, Year) 10/11/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Vallecillo, MD. 4000 Annapolis Rd Baltimore, MD 21227			
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Benjamin B. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32117

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNABELLE ROTH-DUFFY				2. Date of Death Month Day Year OCTOBER 11, 2000		3. Time of Death 5:00 A.M.
	4a. Facility Name (If not institution, give street and number) 6117 MOYER AVENUE				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A
Funeral Director	5. Social Security Number 209-24-8607	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	8. Date of Birth (Month, Day, Year) 9/27/32	9. Birthplace (State or Foreign Country) VIRGINIA		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 6117 MOYER AVENUE		10f. Zip Code 21206		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		
	16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) HENRY SHERRY		18. Mother's Name (First, Middle, Maiden Surname) ANNABELLE UNAVAILABLE		
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) DIANA BROWN DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6117 MOYER AVENUE BALTIMORE, MD 21206				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM.		Date 10/13/00	20c. Location - City or Town, State PARKVILLE, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic coronary artery disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>						
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number A21022		29d. Date signed (Month, Day, Year) 10-12-00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. KOWALOWSKI 7676 BROWN RD BALTIMORE 21236						
	31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32118

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Issac Duffie Jr.		2. Date of Death Month Day Year OCT. 8, 2000		3. Time of Death 11:38 AM
	4a. Facility Name (If not institution, give street and number) 533 NORTH BRICE STREET		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
Funeral Director	5. Social Security Number 218-44-6037	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 11 27 44		9. Birthplace (State or Foreign Country) M.D.		
Usual Residence of Decedent					
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 3342 Dolfield Ave			10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) na		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver		16b. Kind of Business/Industry Cab Company	
17. Father's Name (First, Middle, Last) Issac Duffie Sr.			18. Mother's Name (First, Middle, Maiden Surname) Katie Pringle		
19a. Informant's Name/Relationship (Type, Print) Delores Duffie-Sister			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3342 Dolfield Ave, Baltimore Md 21215		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 10/14/2000 Owings Mills, Md	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32119

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Florence M. Dayton

2. Date of Death

Month Day Year
Oct. 10, 2000

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

salisbury, Md.

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

058-09-3348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 15, 1906

9. Birthplace (State or Foreign Country)

Brooklyn, NY

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury Maryland

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

100 East Carroll Street

10f. Zip Code

21801

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unk.

College (1-4 or 5+)

Unk.

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Insurance

17. Father's Name (First, Middle, Last)

Douglas Cunningham

18. Mother's Name (First, Middle, Maiden Surname)

Caroline Cudlipp

19e. Informant's Name/Relationship (Type, Print)

Adrienne Waring / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7516 Titleist Drive, Salisbury Maryland 21801

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Cemetery, October 13, 2000

Data

20c. Location - City or Town, State

Brooklyn, NY

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Plasmoturbence, massive (Day

Due to (or as a consequence of):

b. Colon Cancer years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple causesChronic leg ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 39813

29d. Date signed (Month, Day, Year)

10/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Benjamin P. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

FLORENCE MAY DAYTON
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

00-5735-510
cm
Jennifer Echenique

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 32120
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jennifer Lorena Echenique				2. Date of Death Month Day Year October 07, 2000		3. Time of Death 8:30 P.M.	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-29-0825		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 19 Yrs.		8. Date of Birth (Month, Day, Year) July 12, 1981	
	9. Birthplace (State or Foreign Country) Honduras		10a. State MD.		10b. County Prince George		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 13008 Old Stage Coach Road			
	10f. Zip Code 20708				10g. Citizen of What Country? Honduras (green card)			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Hondurian		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Auto Insurance			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Gustavo A. Echenique				18. Mother's Name (First, Middle, Maiden Surname) Patricia Valle			
	19a. Informant's Name/Relationship (Type, Print) Gustavo A. Echenique- Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13008 Old Stage Coach Road, Laurel, Maryland 20708			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gates of Heaven		Date October 10, 2000		20c. Location - City or Town, State Silver Spring, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road, Laurel, Maryland 20707					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Adult Respiratory Distress Syndrome Due to (or as a consequence of): b. Septic Shock Due to (or as a consequence of): c. Renal Failure Due to (or as a consequence of): d. Multiple Traumatic Injuries							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? Approval 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 09-26-2000		28b. Time of Injury 10:53 P M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred Subject was the driver of a car which collided with another car.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Road		28f. Location (Street and Number or Rural Route Number, City or Town, State) 13710 Laurel Bowie Rd. Laurel, Maryland.			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number MD 3055		29d. Date signed (Month, Day, Year) October 09, 2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NADER HABASHI 22 South Greene St., Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 			


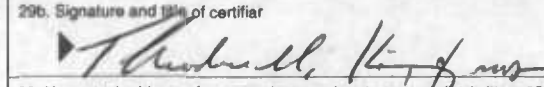

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32121

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANDREW G. ESER				2. Date of Death Month Day Year October 10, 2000				3. Time of Death 2:44 A.M.	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-29-3890		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 18 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Aug. 12 1982		9. Birthplace (State or Foreign Country) Ohio		10e. State Md.		10b. County Anne Arundel Co.		10c. City, Town or Location Pasadena	
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 1903 Orchard Point Road		10f. Zip Code 21122		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry Education		17. Father's Name (First, Middle, Last) Karl R. Eser		18. Mother's Name (First, Middle, Maiden Surname) Linda S. Beadle		19a. Informant's Name/Relationship (Type, Print) Karl and Linda Eser (Parents)		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Orchard Point Road, Pasadena, Md. 21122		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Carmel Cemetery		20c. Location - City or Town, State Pasadena, Md.		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) 10-09-2000		
28b. Time of Injury 7:02 P M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred Driver of vehicle involved in vehicular accident.		28e. Location (Street and Number or Rural Route Number, City or Town, State) Magpie Bridge Road near Metispa Dr., Severna Park, MD		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and Title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 10, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) OCT 12 2000		
32. Registrar's Signature 		33. State Registrar State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.		36. To Be Completed by Physician/Medical Examiner		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32122

amend item 23a, pt II, 27, 28a, b, c, d, e, f per me G788 10/18/00

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary JoAnn Edmondson				2. Date of Death Month Day Year SEPTEMBER 30, 2000		3. Time of Death 22:32 PM	
	4a. Facility Name (If not institution, give street and number) 1146 GLORIA AVENUE				4b. City, Town, or Location of Death Baltimore		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 218-36-9377	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 8, 1939		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1146 Gloria Avenue				10f. Zip Code 21227		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerical			16b. Kind of Business/Industry Westinghouse	
17. Father's Name (First, Middle, Last) Joseph Bawroski				18. Mother's Name (First, Middle, Maiden Surname) Doris Stierhoff				
19a. Informant's Name/Relationship (Type, Print) Marcie Smith/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Carl Avenue, Glen Burnie, Maryland 21060				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 10-5-00		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Lisa S. Jefferson</i>				22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PROPOXYPHENE INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MESOTHELIOMA OF LUNG						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 9/30/00		28b. Time of Injury found 10:25 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject took drug overdose
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 1146 Gloria Avenue Arbutus, Maryland				
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Maureen Jane Hall</i>				29c. License number OCME		29d. Date signed (Month, Day, Year) OCTOBER 01, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARYANN D. KORSU 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature <i>B. Spauld</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32123

AMEND ITEM: 20B -20C PER F.H. G789 11-29-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wade Farmer				2. Date of Death Month: 10 Day: 08 Year: 00		3. Time of Death 05:40	
	4a. Facility Name (If not institution, give street and number) Bon Secours Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 239-22-4255		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 3, 1921	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1701 Bloomingdale Rd.		10f. Zip Code 21216		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry City of Balto.		17. Father's Name (First, Middle, Last) unk	
	18. Mother's Name (First, Middle, Maiden Surname) unk		19a. Informant's Name/Relationship (Type, Print) (Niece) Ms. Gladys Green		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3641 Gelston Drive Balto. Md. 21229		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		20c. Date 10/19/00		20d. Location - City or Town, State LANSLOWNE, MD		21. Signature of Funeral Service Licensee Joseph L. Russ	
	22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RENAL FAILURE		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Edward Obregon		29c. License number D41430		29d. Date signed (Month, Day, Year) Oct 9th 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BONSECOURS HOSPITAL 2000 WEST BALTIMORE ST MD 21223		31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32124

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ed Felder, SR.			2. Date of Death Month 10 Day 2 Year 2000			3. Time of Death 9:15AM			
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Medical Center			4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 247-20-2939		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 11-25-16		9. Birthplace (State or Foreign Country) SC	
	Usual Residence of Decedent									
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 123 W. 29th Street				10f. Zip Code 21218			10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sergeant First Class U.S. Army			16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) Lawrence Felder				18. Mother's Name (First, Middle, Maiden Surname) Emma Mackwood						
19a. Informant's Name/Relationship (Type, Print) Ed Felder, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1545 Wadworth Way Baltimore, Maryland 21239						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. 10-23-2000 Owings Mills			20c. Location - City or Town, State MD				
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stroke Due to (or as a consequence of): b. Multiple myeloma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier [Signature] medical resident				29c. License number PKS-000			29d. Date signed (Month, Day, Year) 10/2/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Ave, Baltimore, MD 21224										
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


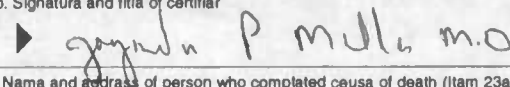
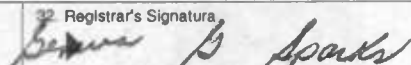
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32125

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carmie M. Fitzgerald		2. Date of Death Month Day Year OCTOBER 9, 2000		3. Time of Death 5:15 AM
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 219-10-6559	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) 07 11 26		9. Birthplace (State or Foreign Country) M.D.		
Usual Residence of Decedent					
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 2519 North Ellamont Street			10f. Zip Code 21216		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Navar Marriad <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) na		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dietician		16b. Kind of Business/Industry V.A. Hospital	
17. Father's Name (First, Middle, Last) William Hardy			18. Mother's Name (First, Middle, Maiden Surname) Ruby DeShields		
19a. Informant's Name/Relationship (Type, Print) Diane Watts-Niece			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 Lydonlea Way, Baltimore Md 21239		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 10/13/2000 Glen Burnie, Md	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ADVANCED METASTATIC SMALL CELL LUNG CANCER					Approximate Interval Between Onset and Death
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was causa referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D0041410	29d. Date signed (Month, Day, Year) October 9th, 2000
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-388-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32126

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Griser				2. Date of Death Month Day Year October 7, 2000				3. Time of Death 9:30pm																															
	4a. Facility Name (If not institution, give street and number) 12005 Lanner Place				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince Georges																															
Funeral Director	5. Social Security Number 196-20-9756		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) February 7, 1917		9. Birthplace (State or Foreign Country) PA																															
	Usual Residence of Decedent																																							
To Be Completed by Funeral Director	10a. State MD		10b. County Prince Georges		10c. City, Town or Location Laurel				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																															
	10e. Street and Number 12005 Lanner Pl.				10f. Zip Code 20708		10g. Citizen of What Country? USA																																	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Unk.		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse			16b. Kind of Business/Industry Medical																																
	17. Father's Name (First, Middle, Last) Edward Ross Spencer				18. Mother's Name (First, Middle, Maiden Surname) Katherine Blanche Ault																																			
	19a. Informant's Name/Relationship (Type, Print) Betty Gooding / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12005 Lanner Pl., Laurel Maryland 20708																																			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) National Cem.		Date October 12, 2000		20c. Location - City or Town, State Memphis, TN																																	
	21. Signature of Funeral Service Licensee Victor P. Doda, Jr.				22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230																																			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																							
	<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Metastatic Pancreas Cancer</td> <td rowspan="4">Approximate Interval Between Onset and Death 6 Months</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metastatic Pancreas Cancer	Approximate Interval Between Onset and Death 6 Months	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):																								
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	b. Due to (or as a consequence of):																																							
	c. Due to (or as a consequence of):																																							
	d. Due to (or as a consequence of):																																							
<table border="1"> <tr> <td colspan="4">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</td> <td colspan="2">23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="4"></td> <td colspan="2"></td> </tr> <tr> <td colspan="4"></td> <td colspan="2">24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="4"></td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>										Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown												24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day, Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="3">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>										25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																																
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																								
29b. Signature and title of certifier Martin D. Weltz, MD				29c. License number D23743		29d. Date signed (Month, Day, Year) October 7, 2000																																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz, MD 7525 Greenway Court, Greenbelt MD 20770																																								
31. Date filed (Month, Day, Year) OCT 12 2000																																								
32. Registrar's Signature [Signature]																																								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32127

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES GELDER				2. Date of Death Month OCTOBER Day 10th Year 2000				3. Time of Death 11:20 p.m.	
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A	
Funeral Director	5. Social Security Number 199-20-3455		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) Jan. 14, 1927		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1210 Locust Ave.				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-1954		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Medical		17. Father's Name (First, Middle, Last) Lawrence H. Gelder		18. Mother's Name (First, Middle, Maiden Surname) Jean Gregg		19a. Informant's Name/Relationship (Type, Print) Sheila L. Gelder, wife		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Locust Ave. Baltimore, MD. 21227		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Location - City or Town, State Elkridge, MD		20d. Date 10-14-00		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC COLON CANCER. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 4 MONTHS				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 10-14-00		28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  2nd Year Surgery Resident		29c. License number AS2438528 1187		29d. Date signed (Month, Day, Year) OCTOBER 10th, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVINASH L. GANTI, ST. AGNES HEALTHCARE 900 CATON AVENUE, BALTIMORE, MD 21229		31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32128

Amended Item#20b,20c perFHG788 10/16/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NELLIE GANTT				2. Date of Death Month 10 Day 10 Year 2000		3. Time of Death 0230	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 220-36-4550		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 07-17-42	9. Birthplace (State or Foreign Country) NC
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Columbia		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7660 Wood Park Lane				10f. Zip Code 21046		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Baltimore City Public Schools		
17. Father's Name (First, Middle, Last) Claude Wiggins				18. Mother's Name (First, Middle, Maiden Surname) Susanna Royster				
19a. Informant's Name/Relationship (Type, Print) Karen Conyers				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11125 Slalom Lane Columbia, Maryland 21044				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK CEM.		Date 10-16-2000		20c. Location - City or Town, State Randallstown, MD		
21. Signature of Funeral Service Licensee Y. Ladys W. Wane				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HEART SURGERY Due to (or as a consequence of): MYOCARDIAL INFARCTION Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY - END STAGE Due to (or as a consequence of): CORONARY ARTERY DISEASE								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Kurt Wehberg MD, RESIDENT				29c. License number 046536		29d. Date signed (Month, Day, Year) 10/10/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KURT WEHBERG, M.D. 22 SOUTH GREENE STREET, BALTIMORE MD 21201								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32129

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Faith Annette Grant				2. Date of Death Month Day Year October 10 2000				3. Time of Death 8:20 PM		
	4a. Facility Name (If not institution, give street and number) Spa Creek Genesis Eldercare				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 222-54-9564		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) APR 12, 1964		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						
10e. Street and Number 35 Milkshake Lane				10f. Zip Code 21401				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Clerk				16b. Kind of Business/Industry Department of Motor Vehicles			
17. Father's Name (First, Middle, Last) James Hoffman				18. Mother's Name (First, Middle, Maiden Surname) Ruth Carr							
19a. Informant's Name/Relationship (Type, Print) Ruth Mercante/Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Brennan Dr. Newark, DE 19713							
20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.				20c. Location - City or Town, State 10-11-00 Baltimore, MD			
21. Signature of Funeral Service Licensee Edward A. Gregorik				22. Name and Address of Facility Cremation Society of MD, Inc.				22. Name and Address of Facility 299 Frederick Road Baltimore, MD 21228			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Encephalopathy Due to (or as a consequence of): b. Toxemia of Pregnancy Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 1 month	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number D 38958	
29b. Signature and title of certifier Dr. S. S. S. MD				29d. Date signed (Month, Day, Year) 10/11/2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daljeet Singh Sicker 1413 Annapolis Road #106 Odenton MD 21113											
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature B. Spauld							

Examination of
Fingerprint

10/11/2004

D 38428

Bill MD

Defect Right Biller 113 Thompson Road #100 Clinton

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32130

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen A. Gartrell		2. Date of Death Month October Day 10 Year 2000		3. Time of Death 9:25 am						
	4a. Facility Name (If not institution, give street and number) Stella Maris		4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore						
Funeral Director	5. Social Security Number 212-40-5711	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) Aug 6, 1908		9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent											
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Reisterstown							
10e. Street and Number 301 Butler Road		10f. Zip Code 21136		10g. Citizen of What Country? U.S.A.							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary							
16b. Kind of Business/Industry Board of Education		17. Father's Name (First, Middle, Last) David M. Bucher		18. Mother's Name (First, Middle, Maiden Surname) Effie M. Crowther							
19a. Informant's Name/Relationship (Type, Print) Richard C. Bandiere Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Ridgely Road Lutherville, MD 21093									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Mem. Gardens		20c. Location - City or Town, State 10/13/00 Finksburg, MD							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a. <u>METASTATIC DISEASE</u> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <u>METASTATIC DISEASE</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):	d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <u>METASTATIC DISEASE</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death									
	b. _____ Due to (or as a consequence of):										
	c. _____ Due to (or as a consequence of):										
	d. _____ Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M							
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 		29c. License number D 15504		29d. Date signed (Month, Day, Year) 10 10 00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093											
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32131

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward Lee Green

2. Date of Death

October 7, 2000

3. Time of Death

2 A.M.

4a. Facility Name (If not institution, give street and number)

6930 Brookmill Road

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

219-56-6915

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 26, 1965

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

City

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6930 Brookmill Road

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Man

16b. Kind of Business/Industry

Bowling Alley

17. Father's Name (First, Middle, Last)

Edgar L. Green Jr.

18. Mother's Name (First, Middle, Maiden Summa)

Jean P. Evans

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jean P. Green (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3560 Carriage Hill Circle Randallstown, Md. 21133

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Service

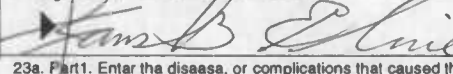
Date

10/9/00

20c. Location - City or Town, State

Hampstead, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

11824 Reisterstown Road
Eline Funeral Home Reisterstown, Md. 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 2 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. NON-ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

25 yrs

c. HYPERTENSION

Due to (or as a consequence of):

76 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

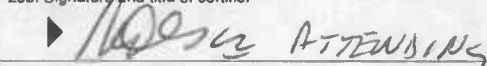
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D 40390

29d. Date signed (Month, Day, Year)

OCTOBER 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. R. DESAI, MD, 23 CROSS ROAD 5 DRIVE, #325, DOWNS MILLS, MD 21117

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

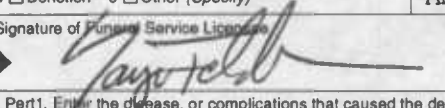
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32132

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES P. GLUSHAKOW				2. Date of Death Month OCTOBER Day 11 , Year 2000		3. Time of Death 2:00 AM	
	4a. Facility Name (If not institution, give street and number) 7500 SHELOWOOD ROAD				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-16-8631	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 7, 1924		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7500 SHELOWOOD ROAD				10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER/PROPRIETOR		16b. Kind of Business/Industry BEAUTY SALON		
17. Father's Name (First, Middle, Last) ELLIS POLSKY				18. Mother's Name (First, Middle, Maiden Surname) ANNA SHERRY				
19a. Informant's Name/Relationship (Type, Print) STEPHEN M. GLUSHAKOW / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7500 SHELOWOOD ROAD - BALTIMORE, MD 21208				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANSHE EMUNAH (AITZ CHAIM)		Date 10/11/00		20c. Location - City or Town, State BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer Due to (or as a consequence of): b. COPD Due to (or as a consequence of): c. Hyperlipidemia Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		29c. License number D23985		29d. Date signed (Month, Day, Year) 10/11/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JY. GROSS M.D. 6569 N. Charles St Balto 21204								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28c-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32133

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LETITIA R. GORDON

2. Date of Death

OCTOBER 9, 2000

3. Time of Death

2:06 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

217-18-9174

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APR. 29, 1923

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3198 OLD POST DRIVE #3

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INCOME MAINTENANCE SPECIALIST BALTO. CITY DEPT. OF

16b. Kind of Business/Industry

SOCIAL SERVICES

17. Father's Name (First, Middle, Last)

LOUIS

18. Mother's Name (First, Middle, Maiden Surname)

ZUSKIN

BLANCHE

SAMUELS

19a. Informant's Name/Relationship (Type, Print)

BERNARD GORDON / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3198 OLD POST DRIVE #3 - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW CEMETERY 10/11/00 REISTERSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

1 HOUR

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEPRESSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ SOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47587

29d. Date signed (Month, Day, Year)

OCTOBER 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT FINE, MD, 5401 OLD COURT ROAD, RANDALLSTOWN, MD 21133

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32134

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LISTON A. GEORGE JR.				2. Date of Death Month Day Year October 10 2000				3. Time of Death 4 35 PM		
	4a. Facility Name (If not institution, give street and number) STELLA MARIS @ MERCY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A		
Funeral Director	5. Social Security Number 244-90-7273		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) 1-21-1953		9. Birthplace (State or Foreign Country) MD.		
	Usual Residence of Decedent										
10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2120 ST. PAUL ST. APT. 3				10f. Zip Code 21218				10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4or 5+) -2-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER				16b. Kind of Business/Industry RETAIL			
17. Father's Name (First, Middle, Last) LISTON A. GEORGE SR.				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY GIBBS							
19a. Informant's Name/Relationship (Type, Print) LISTON A. GEORGE SR(FATHER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 SUTER RD. CATONSVILLE, MARYLAND 21228							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY				20c. Location - City or Town, State 10-13-2000 BALTIMORE, MARYLAND			
21. Signature of Funeral Service Licensee ▶ <i>Janatha D. Huzner</i>				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Lung Cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>STELLA MARIS AT MERCY HOSPICE</i>							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier ▶ <i>David R. Riseberg</i>				29c. License number D40854				29d. Date signed (Month, Day, Year) October 10, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202											
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature ▶ <i>Benita S. Sparks</i>							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32135

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold L. Hughes				2. Date of Death Month Oct. Day 9 Year 2000		3. Time of Death 3:30 pm	
	4a. Facility Name (If not institution, give street and number) 5513 Medwick Garth South				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 213-16-8668		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 19 1922	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 5513 Medwick Garth South				10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 42-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) letter carrier		16b. Kind of Business/Industry U.S. Postal Service		
17. Father's Name (First, Middle, Last) Thomas Hughes				18. Mother's Name (First, Middle, Maiden Summa) Mabel Martin				
19a. Informant's Name/Relationship (Type, Print) Mary A. Hughes, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5513 Medwick Garth South, Baltimore, Md. 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Data 10-13-00		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee Handa L Lemmer <i>m00741</i>				22. Name and Address of Facility Witzke Funeral Home, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Ischemic heart disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Stephen J. Plantholt MD						
		29c. License number D23580		29d. Date signed (Month, Day, Year) October 10, 2000				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) STEPHEN PLANTHOLT 3449 WILKES AVE. S. 300, BALTO. MD. 21229								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32136

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Fred David Hubbell, Jr.

2. Date of Death

Month Day Year
OCTOBER 11 2000

3. Time of Death

1235 PM

4a. Facility Name (If not institution, give street and number)

3318 Chesley Ave

4b. City, Town, or Location of Death

Baltimore, Maryland

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

214-24-9552

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 2, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3318 Chesley Avenue

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Korean
Year or Dates: Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Exterminator

16b. Kind of Business/Industry

Self-employed

17. Father's Name (First, Middle, Last)

Fred David Hubbell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Beatrice J. Svec - friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3318 Chesley Avenue, Parkville, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

10/13/00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Laura C. Handberg

22. Name and Address of Facility

CAFA, Stephen D. Lohrmann, P.A.

8717 Green Pastures Drive, Towson, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Hypercholesterolemia

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joy P. Penafiel

29c. License number

D 50087

29d. Date signed (Month, Day, Year)

October 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joy P. Penafiel MD Baltimore VAMC 10 N. Greene Street Baltimore, MD

81201

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

B Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32137

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie B. Hyatt				2. Date of Death Month Day Year October 10, 2000				3. Time of Death 9:20 PM	
	4a. Facility Name (If not institution, give street and number) Mariner Health Care				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220-05-2104		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) July 9, 1920		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lansdowne	
To Be Completed by Funeral Director	10e. Street and Number 204 4th Avenue				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Warren H. Holt				18. Mother's Name (First, Middle, Maiden Surname) Myrtle A. Keppler					
	19a. Informant's Name/Relationship (Type, Print) William W. Hyatt, Jr. / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2241 Glen Alden Drive East, Germantown, TN 38139					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Date 10/14/00		20d. Location - City or Town, State Baltimore, Maryland			
	21. Signature of Funeral Service Licensee Ann Y. Zink				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229					
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA LIVER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 Months					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DEMENTIA, ALZHEIMER'S DIABETES MELLITUS, TYPE II				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Richard E. Fisher MD				29c. License number DO2519		
				29d. Date signed (Month, Day, Year) Oct 11 00						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Richard E. Fisher MD 4710 PENNINGTON Ave, BALTIMORE										
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature Benjamin A. Sparks						

Baltimore, Maryland 21215-0020

Form 10-10-00, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32138

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Loretta Hilton				2. Date of Death Month Day Year OCTOBER 08 2000				3. Time of Death 0212		
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death n/a		
Funeral Director	5. Social Security Number 294-18-6745		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 83		8. Date of Birth (Month, Day, Year) OCTOBER 11 1916		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 508 Lafayette Avenue				10f. Zip Code 21228				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) salesperson				16b. Kind of Business/Industry sales			
17. Father's Name (First, Middle, Last) William Rhoades				18. Mother's Name (First, Middle, Maiden Surname) Louise Reynolds							
19a. Informant's Name/Relationship (Type, Print) Donna Matastasio - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 Lafayette Avenue, Catonsville, Maryland 21228							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 10/11/00 Baltimore, Maryland				20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ann Y Zink				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BILATERAL PNEUMONIA Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death TWO WEEKS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number P14440				29d. Date signed (Month, Day, Year) OCTOBER 8 2000			
29b. Signature and title of certifier ZAKARI ALIYU, MD. ST. AGNES HOSPITAL, BALTIMORE, MD											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature Seneca B. Spauls							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32139

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE M. HENNESSY		2. Date of Death Month Day Year October 10, 2000		3. Time of Death 1:40 P.M.
	4a. Facility Name (If not institution, give street and number) 106 East Fort Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 214-38-6114	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Sept. 19 1938		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 106 E. Fort Ave.			10f. Zip Code 21230		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pressman		16b. Kind of Business/Industry Gamses Lithiograph Company	
17. Father's Name (First, Middle, Last) Melvin Hennessy			18. Mother's Name (First, Middle, Maiden Surname) Audrey Wagner		
19a. Informant's Name/Relationship (Type, Print) Mary A. Hennessy (Daughter)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 Parksley Ave. Baltimore, Md. 21230		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		20c. Location - City or Town, State 10/14/2000 Baltimore, Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 11, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LABON WOLF, MD 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

00 32140

Reg. No.

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32141

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Vernon J. Horn				2. Date of Death Month Day Year October 10, 2000				3. Time of Death 3:31AM	
	4e. Facility Name (If not institution, give street and number) 2725 Mayberry Road				4b. City, Town, or Location of Death Taneytown				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-36-9938		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Aug. 28, 1941		9. Birthplace (State or Foreign Country) MD		Usual Residence of Decedent		10a. State MD		10b. County Carroll	
To Be Completed by Funeral Director	10c. City, Town or Location Taneytown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 2725 Mayberry Road	
	10f. Zip Code 21787				10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postmaster				16b. Kind of Business/Industry United States Post Office	
	17. Father's Name (First, Middle, Last) Byron L. Horn				18. Mother's Name (First, Middle, Maiden Surname) Jessie Wheeler				19a. Informant's Name/Relationship (Type, Print) Barbara O. Horn Sister	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2725 Mayberry Rd., Taneytown, MD 21787				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gard.	
	20c. Location - City or Town, State Timonium, MD				21. Signature of Funeral Service Licensee Eline Funeral Home				22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136	
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer				Approximate Interval Between Onset and Death 6 months				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	23c. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23d. Due to (or as a consequence of):				23e. Due to (or as a consequence of):	
	23f. Due to (or as a consequence of):				23g. Due to (or as a consequence of):				23h. Due to (or as a consequence of):	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier INTERNIST, MD				29c. License number D 52035	
State Registrar	29d. Date signed (Month, Day, Year) October 10, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BINU CHACKO 291 Stoner Avenue Westminster MD 21157				31. Date filed (Month, Day, Year) OCT 12 2000	
	32. Registrar's Signature Beverly S. Sparks									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00-32142

REPLACEMENT

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Samuel Jagers		2. Date of Death Month September Day 26 Year 00		3. Time of Death 4:15 PM	
4a. Facility Name (If not institution, give street and number) Mariner Health of Silver Spring			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 428-14-2138	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/16/1920
9. Birthplace (State or Foreign Country) Liberty, Ms.		Usual Residence of Decedent			
10e. State D C	10b. County	10c. City, Town or Location Washington		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1401 Hemlock Street, N.W.		10f. Zip Code 20012		10g. Citizen of What Country? U. S. A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1/20/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ yrs		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professional Officer	
17. Father's Name (First, Middle, Last) Aaron Jagers		18. Mother's Name (First, Middle, Maiden Surname) Lena Caston			
19e. Informant's Name/Relationship (Type, Print) Carole Jagers / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Hemlock Street, N.W. Washington, DC 20012			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		20c. Location - City or Town, State 10/5/00 Arlington, Va.	
21. Signature of Funeral Service Licensee <i>John W. Latney</i>		22. Name and Address of Facility Latney's Funeral Home Inc. 3831 Georgia Avenue, N.W. Wash., DC 20011			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. PNEUMONIA Due to (or as a consequence of): b. Severe dementia (vascular) Due to (or as a consequence of): c. arteriosclerotic heart disease Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 6 hours			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Hypertension				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <i>Barry N. Rosenbaum</i>		29c. License number D09834		29d. Date signed (Month, Day, Year) 11/7/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry N. Rosenbaum 3720 Farragut Avenue, Kensington, Maryland 20895					
31. Date filed (Month, Day, Year) OCT - 6 2000		32. Registrar's Signature <i>Barbara S. Sparks</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32143

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Joseph Kessler				2. Date of Death Month Day Year Oct. 8, 2000		3. Time of Death 9:10AM	
	4a. Facility Name (If not institution, give street and number) 8 Colonial Dr.				4b. City, Town, or Location of Death Linthicum Heights Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 212-34-6641		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1936	
	9. Birthplace (State or Foreign Country) MD		10. Usual Residence of Decedent		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Funeral Director	10e. State MD		10b. County Baltimore		10c. City, Town or Location Linthicum Heights		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8 Colonial Dr.				10f. Zip Code 21090		10g. Citizen of What Country? U.S.A.	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouse		16b. Kind of Business/Industry Courior			
	17. Father's Name (First, Middle, Last) Christian G. Kessler, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Helen A. Slater			
	19a. Informant's Name/Relationship (Type, Print) Elizabeth Kessler, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Colonial Dr. Linthicum Heights, MD. 21090			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State Catonsville, MD		20d. Date 10-12-00	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D25044		29d. Date signed (Month, Day, Year) 10/15/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. REHMAN MD 2717 Hammonds Ferry Rd. Lansdowne, MD. 21227							
State Registrar	31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32144

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>Henrietta Kolb</i>				2. Date of Death Month <i>October</i> Day <i>05</i> Year <i>2000</i>				3. Time of Death <i>0118</i>		
4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital Center</i>				4b. City, Town, or Location of Death <i>Randallstown</i>				4c. County of Death <i>Baltimore</i>		
5. Social Security Number <i>213-01-1807</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>91</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Feb 27, 1909</i>		9. Birthplace (State or Foreign Country) <i>MD</i>		
Usual Residence of Decedent										
10a. State <i>MD</i>		10b. County		10c. City, Town or Location <i>Baltimore</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>6811 Campfield Road</i>				10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>USA</i>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>white</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i>0</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>secretary</i>			16b. Kind of Business/Industry <i>medical</i>			
17. Father's Name (First, Middle, Last) <i>Henry Debelius</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Mildred Hall</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Donna Connelly/niece</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1719 Fleetwood Drive Belair, MD 21015</i>						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		20d. Date		
21. Signature of Funeral Service Licensee <i>Ronald S. Wade, Director</i>				22. Name and Address of Facility <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Pneumonia</i> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>										Approximate Interval Between Onset and Death <i>days</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimers disease</i> <i>Diabetes mellitus</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>D. Roygen</i>				29c. License number <i>D 35844</i>		29d. Date signed (Month, Day, Year) <i>October 05, 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>D Roygen 5401 old Court Road Randallstown MD 21133</i>										
31. Date filed (Month, Day, Year) <i>OCT 12 2000</i>		32. Registrar's Signature <i>[Signature]</i>								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32145

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles R. Lowe		2. Date of Death Month Day Year OCTOBER 10 2000		3. Time of Death 5:25 A.M.
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER		4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 214-30-2983	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Feb. 20, 1934		9. Birthplace (State or Foreign Country) New York		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore
	10c. City, Town or Location Dundalk		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1940 Frames Road		10f. Zip Code 21222		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korean		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Not Known		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Steel Industry		
	17. Father's Name (First, Middle, Last) Winfield Lowe		18. Mother's Name (First, Middle, Maiden Surname) Emily M. Brown		
	19a. Informant's Name/Relationship (Type, Print) Mrs. Pauline L. Lowe (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1940 Frames Road Dundalk, Maryland 21222		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gdns.		20c. Location - City or Town, State 10/13/2000 Middle River, Maryland
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Colon Cancer Due to (or as a consequence of): MALIGANT PLEURAL EFFUSION Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 12 mo				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE EMPHYSEMA				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier M.D.		29c. License number D 45390		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	29d. Date signed (Month, Day, Year) October 10th, 2000				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NYO MDN (M.D.) 6830 HOSPITAL DR. # 206, BALTIMORE, MD 21237				
State Registrar	31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 		
	ORIGINAL				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32146

AMEND#14 PER F.H. G789 11-20-2000 JAB

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALDINE (NMN) LANIER		2. Date of Death Month Day Year OCT. 6, 2000		3. Time of Death 12:30am
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE		4b. City, Town, or Location of Death DULANEY VALLEY		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 226-40-9929	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) NOV. 11, 1931		9. Birthplace (State or Foreign Country) VIRGINIA		
Usual Residence of Decedent					
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1333 PENTWOOD ROAD		10f. Zip Code 21239	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECHNICIAN		16b. Kind of Business/Industry NURSING		17. Father's Name (First, Middle, Last) ELIJAH SHINE	
18. Mother's Name (First, Middle, Maiden Surname) CORA LEE JENKINS		19a. Informant's Name/Relationship (Type, Print) MARIA HOLMAN (DAUGHTER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 B YAKONA RD., PARKVILLE, MD 21234	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		20c. Location - City or Town, State 10/10/00 BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee		22. Name and Address of Facility LOUDON PARK FUNERAL HOME 3620 WILKINS AVE., BALTIMORE, MD 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. GASTRIC CANCER Due to (or as a consequence of):					
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of Certifier 		29c. License number D43725		29d. Date signed (Month, Day, Year) 10/6/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

OCTOBER 6, 2000 12:30 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

GERALDINE LANIER

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32147

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES THOMAS MCKENNA

2. Date of Death
Month Day Year

OCTOBER 10, 2000

3. Time of Death

12:48 PM

4a. Facility Name (If not institution, give street and number)

3515 HARFORD ROAD

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

215-09-6698

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

DECEMBER 23, 1910

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3515 HARFORD ROAD

10f. Zip Code

21218

10g. Citizen of What Country?

UNITED STATES OF AMERICA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12TH GRADECollege (1-4or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

AUDITOR

16b. Kind of Business/Industry

STATE OF MARYLAND

17. Father's Name (First, Middle, Last)

BERNARD J. MCKENNA

18. Mother's Name (First, Middle, Maiden Surname)

MARY A. DORSEY

19a. Informant's Name/Relationship (Type, Print)

URITH E. MCKENNA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3515 HARFORD ROAD / BALTIMORE, MARYLAND 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY

Date

OCT. 14, 2000

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Donald R. Watson, Jr. # M00612

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTIMORE, MD. 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

BRONCHOPNEUMONIA

Due to (or as a consequence of):

COPD

Due to (or as a consequence of):

Chronic Bronchitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF THE COLON

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Miguel Karacushansky, M.D.

29c. License number

D0015462

29d. Date signed (Month, Day, Year)

10/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIGUEL KARACUSHANSKY M.D. 200 E. 33rd St #640 BALTO MD. 21218

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

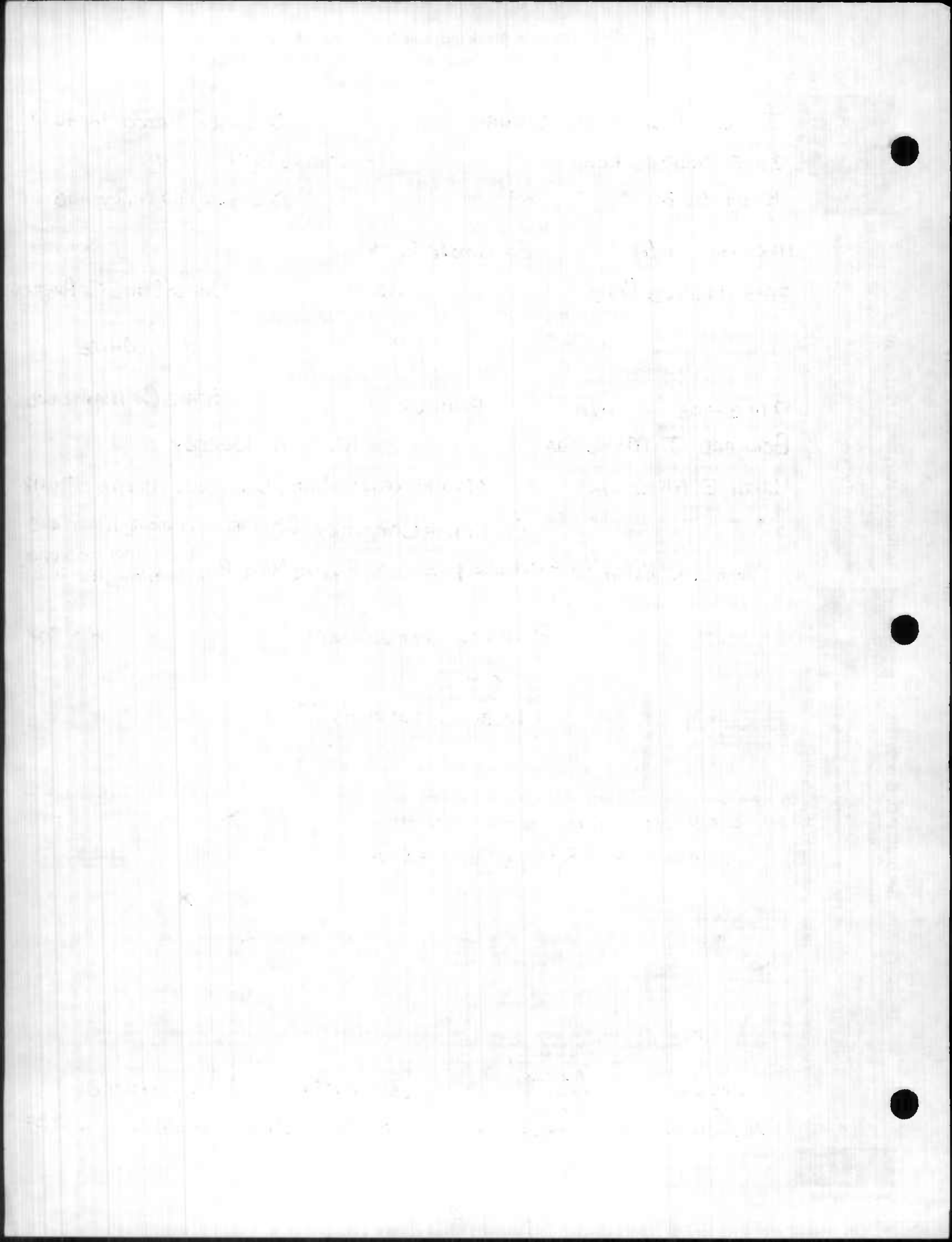
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32148

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) DAVID FRANKLIN MYERS				2. Date of Death Month Day Year OCTOBER 9, 2000				3. Time of Death 15:28 PM	
4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death n/a	
5. Social Security Number 220-20-9592		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) June 29 1929		9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent									
10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 23 E. West Street				10f. Zip Code 21230		10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Taxi Driver				16b. Kind of Business/Industry Transportation	
17. Father's Name (First, Middle, Last) Harry Myers				18. Mother's Name (First, Middle, Maiden Surname) Helen Mildred Marhefka					
19a. Informant's Name/Relationship (Type, Print) Nina Scheppske (Niece)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2373 Hamilton Circle, Baltimore, Md. 21237					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery				Date 10/13/2000		20c. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee  Kevin E. Ecker				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  Theodore King M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 10, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32149

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry F. Matthiesen

2. Date of Death

Month Day Year
OCTOBER 08, 2000

3. Time of Death

6:00 P.M.

4a. Facility Name (If not institution, give street and number)

5801 George Island Landing

4b. City, Town, or Location of Death

Stockton

4c. County of Death

Queen Anne's

Funeral
Director

5. Social Security Number

216-03-5390

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 11, 1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Queen Anne's

10c. City, Town or Location

Stockton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5801 George Island Landing

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self employed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Frederick Matthiesen

18. Mother's Name (First, Middle, Maiden Summe)

Pauline Cathine

19a. Informant's Name/Relationship (Type, Print)

Wayne Matthiesen / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

705 Greentree Rd. Linthicum, MD. 21090

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakeview Cemetery

Date

10-11-00

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Rd. Arbutus, MD. 21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of Colon

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. c/ diffuse metastatic

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Gau.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

Oct 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

ORIGINAL

MATTHIESEN, HENRY

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

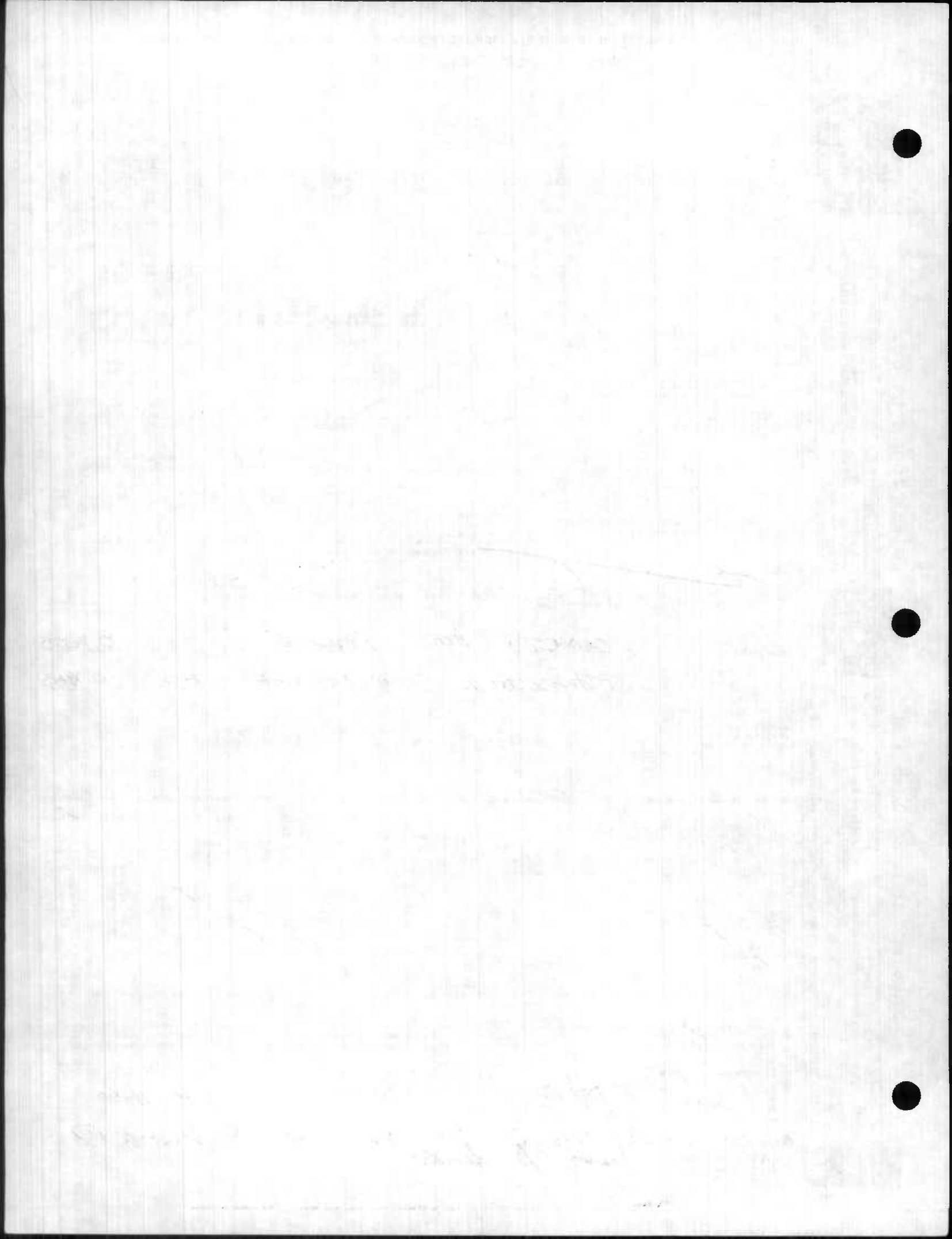
State of Maryland / Department of Health and Mental Hygiene

00 32150

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HUGO L. MATTHEISS				2. Date of Death Month Day Year OCTOBER 11, 2000		3. Time of Death 9:35 A.M.	
	4a. Facility Name (If not institution, give street and number) 1911 REDWOOD AVENUE				4b. City, Town, or Location of Death PARKVILLE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 212-07-1128		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) 12/5/08	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location PARKVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1911 REDWOOD AVENUE		10f. Zip Code 21234		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST		16b. Kind of Business/Industry MANUFACTURING			
	17. Father's Name (First, Middle, Last) WILLIAM H. MATTHEISS				18. Mother's Name (First, Middle, Maiden Surname) CAROLYN BESSLER			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES MATTHEISS SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 REDWOOD AVENUE PARKVILLE, MD 21234			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Piece of Disposition (Name of cemetery, crematory or other place) MORELAND MEM. PARK		20c. Location - City or Town, State 10/14/00 HILLENDALE, MD		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286			
	23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 8 YEARS 10 YEARS							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number D31189				29d. Date signed (Month, Day, Year) 10-11-00			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. MINNISOFT, MD 8813 WATKINS WOODS RD, BARTOW, FL							
	31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32151

Amended Item #4b,7 per FHG7888 10/17/2000 EW

AMEND#4B PER M.E. G788 10-12-2000 JAB

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Sandra Minor		2. Date of Death Month Day Year October 07, 2000		3. Time of Death 0825 am
	4a. Facility Name (If not institution, give street and number) Malcolm Grow USAF Medical Center		4b. City, Town, or Location of Death CAMP SPRINGS Andrews Air Force		4c. County of Death Prince George's
Funeral Director	5. Social Security Number 219-58-8368	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 46 47 Yrs.	8. Date of Birth (Month, Day, Year) Oct 10, 1953	9. Birthplace (State or Foreign Country) Washington D.C.
	Usual Residence of Decedent				
10a. State MD		10b. County Prince Georges'	10c. City, Town or Location Forestville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 1908 Rochelle Avenue #1513			10f. Zip Code 20747	10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bindery Assistant		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Herbert R. Brown			18. Mother's Name (First, Middle, Maiden Surname) Louise F. Hamilton		
19a. Informant's Name/Relationship (Type, Print) Frank A. Minor III - Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9509 Hobart Street Springdale MD 20774		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 10-14-00	20d. Location - City or Town, State Landover Maryland
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIAC TAMPONADE</u> Due to (or as a consequence of): b. <u>RUPTURE OF ASCENDING AORTA</u> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 08, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

per M.L. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32152
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Sherry Morgan		2. Date of Death Month Day Year October 07, 2000		3. Time of Death 11:03 A.M.	
4a. Facility Name (If not institution, give street and number) 4400 Franconia Road		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 215-84-8824		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.	
8. Data of Birth (Month, Day, Year) 12-23-72		9. Birthplace (State or Foreign Country) MD		10. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex	
10d. Street and Number 702 Snowberry Court Apt. G		10e. Zip Code 21221		10f. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer	
16b. Kind of Business/Industry Beckers & Deckers		17. Father's Name (First, Middle, Last) Gregory Morgan		18. Mother's Name (First, Middle, Maiden Surname) Lois Fleming	
19a. Informant's Name/Relationship (Type, Print) Lois Fleming		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 N. Calhoun Street 3rd. Fl. Baltimore, MD 21223		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery 10-16-2000 Woodlawn, MD.		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee Gladys W...	
22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stab and Cutting Wounds, Blunt Force Injuries, and Asphyxiation		Approximate Interval Between Onset and Death	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) Found: 10-07-2000		28b. Time of Injury Found: 11:26 A		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred Subject was beaten, stabbed, cut, and asphyxiated.		28e. Location (Street and Number or Rural Route Number, City or Town, State) Found: 4400 Franconia Road, Baltimore, MD		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier J.M. Clark for		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 08, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis Chute M.D., 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Sparks	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32153

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kathy Ann Matheson				2. Date of Death Month Day Year October 9 2000				3. Time of Death 11:50 AM						
	4a. Facility Name (If not institution, give street and number) 1652 Cananaro Drive				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel						
Funeral Director	5. Social Security Number 008-56-3704		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 39 Yrs.		8. Date of Birth (Month, Day, Year) DEC 31, 1960		9. Birthplace (State or Foreign Country) Germany						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 1652 Cananaro Drive				10f. Zip Code 21401				10g. Citizen of What Country? USA							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Registered Nurse				16b. Kind of Business/Industry Hospital							
17. Father's Name (First, Middle, Last) Albert G. Delude				18. Mother's Name (First, Middle, Maiden Surname) Beverly M. Partlow											
19a. Informant's Name/Relationship (Type, Print) Keith D. Matheson/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1652 Cananaro Dr. Annapolis, MD 21401											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.				20c. Location - City or Town, State 10-10-00 Baltimore, MD							
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Metastatic Colorectal Cancer</td> <td rowspan="4">2 yrs</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metastatic Colorectal Cancer	2 yrs	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metastatic Colorectal Cancer	2 yrs													
	b. Due to (or as a consequence of):														
	c. Due to (or as a consequence of):														
	d. Due to (or as a consequence of):														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier John M. Hall, MD				29c. License number 18870 (D.C.)				29d. Date signed (Month, Day, Year) 10/10/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John M. Hall, MD National Naval Medical Ctr, Bethesda, MD															
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature B. Sparks													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32154

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bascomi William Mason Jr</i>				2. Date of Death Month <i>October</i> Day <i>8</i> Year <i>2000</i>		3. Time of Death <i>04:35</i>	
	4a. Facility Name (If not institution, give street and number) <i>John Hopkins Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>214-58-5147</i>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>48</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>3-1-1952</i>	
	9. Birthplace (State or Foreign Country) <i>MD.</i>		10a. State <i>MD.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <i>3017 McELDERRY ST.</i>		10f. Zip Code <i>21205</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>-12-</i> College (1-4 or 5+) <i>-0-</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>DISABLED</i>		16b. Kind of Business/Industry <i>N/A</i>			
	17. Father's Name (First, Middle, Last) <i>BASCOMI MASON SR.</i>				18. Mother's Name (First, Middle, Maiden Summa) <i>RUBY MOSES</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>MELINDA A. MASON(DAUGHTER)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>533 N. GLOVRE ST. BALTIMORE, MARYLAND 21205</i>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>ARBUTUS MEMORIAL PARK</i>		20c. Location - City or Town, State <i>10-11-2000 BALTIMORE, MARYLAND</i>			
	21. Signature of Funeral Service Licensee <i>Svenivere Redd</i>		22. Name and Address of Facility <i>REDD FUNERAL SERVICE</i> <i>1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. signet cell carcinoma of the bladder</i> Due to (or as a consequence of): <i>b.</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Acute on Chronic Renal Failure</i> <i>Urinary Tract Infection</i>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Svenivere Redd MD</i>				29c. License number <i>RES-000</i>		29d. Date signed (Month, Day, Year) <i>October 8, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Hetty Carraway, MD Johns Hopkins Hospital Tower 110 Baltimore Maryland 21205</i>								
State Registrar	31. Date filed (Month, Day, Year) <i>OCT 12 2000</i>		32. Registrar's Signature <i>Svenivere Redd</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32155

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Newell						2. Date of Death Month October Day 4 Year 2000		3. Time of Death 8:23PM		
	4a. Facility Name (If not institution, give street and number) 218 Stonewall Road						4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 082-16-6624		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) July 28, 1907		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent										
10a. State MD.		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 218 Stonewall Road						10f. Zip Code 21228		10g. Citizen of What Country? Usa			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Cook				16b. Kind of Business/Industry School Cafeteria			
17. Father's Name (First, Middle, Last) Antonio Ruggiero						18. Mother's Name (First, Middle, Maiden Surname) Elisabetta Greco					
19a. Informant's Name/Relationship (Type, Print) Elizabeth Pasquella-Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Stonewall Road, Catonsville, Maryland 21228					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore/Washington Crem		20c. Location - City or Town, State Laurel, Maryland		20d. Date October 9, 2000			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Witzke Funeral Home 1630 Edmondson Avenue, Catonsville, Maryland 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Alzheimer's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 10 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D 38762		29d. Date signed (Month, Day, Year) October 12, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon J. Mc Cormack MD - Baltimore, Md. 21229											
31. Date filed (Month, Day, Year) Oct 12 2000						32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

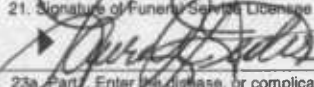
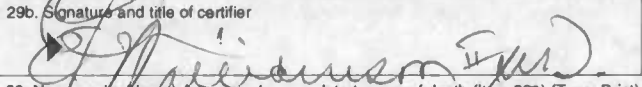
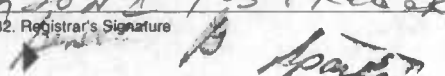
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32156

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alexandra Obaturow						2. Date of Death Month Day Year OCTOBER 10 2000		3. Time of Death 1 AM	
	4a. Facility Name (If not institution, give street and number) 431 Chalfonte Drive						4b. City, Town, or Location of Death Catonsville		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-30-6631		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) November 20, 1904		9. Birthplace (State or Foreign Country) Latvia	
	Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Catonsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 431 Chalfonte Drive						10f. Zip Code 21228		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Philip Kulakov						18. Mother's Name (First, Middle, Maiden Surname) Anna Shelkovskaja				
19a. Informant's Name/Relationship (Type, Print) Anastasia Norko- Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Chalfonte Drive, Catonsville, Maryland 21228				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) ST. Andrews Orthodox Cemetery			Date October 12, 2000		20c. Location - City or Town, State Dundalk, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YEARS										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number 211171		29d. Date signed (Month, Day, Year) OCTOBER 10, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILLIAMSON 405 FREDERICK ROAD CATONSVILLE 21228 MARYLAND										
31. Date filed (Month, Day, Year) OCT 12 2000			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edward P. O'Byrne Sr.

2. Date of Death

October 10, 2000

3. Time of Death

9:45 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

719 Maiden Choice Lane HR 341

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

212-03-9590

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 1, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 Maiden Choice Lane, HR 341

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Letter Carrier

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Thomas O'Bryne

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Warren

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Vonasek / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2612 E. Northern Parkway, Baltimore, Maryland 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

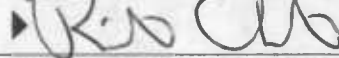
Date

10/12/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hubbard Funeral Home, Inc.
4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier



29c. License number

D 26473

29d. Date signed (Month, Day, Year)

October 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bernard F. Koborsky, MD 711 Maiden Choice Lane, BALTO MD 21220

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

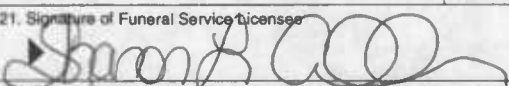
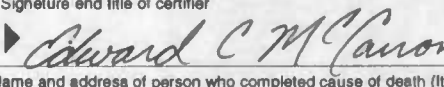
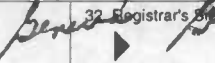
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32158

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Orloskey Jr.				2. Date of Death Month Day Year OCTOBER 3 2000		3. Time of Death 7:17 P.M.									
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE									
Funeral Director	5. Social Security Number 212-20-3771		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Sept 19, 1924									
	9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Baltimore		10c. City, Town or Location Rosedale									
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 8024 Old Philadelphia Road		10f. Zip Code 21237										
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Press Operator		16b. Kind of Business/Industry Industrial										
17. Father's Name (First, Middle, Last) Joseph Orloskey Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna Buhovesky												
19a. Informant's Name/Relationship (Type, Print) Carol Weinreich/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11736 Browntown Road Kennedyville MD 21645												
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 10-7-00		20c. Location - City or Town, State Baltimore MD										
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. RUPTURED HEART</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. RIGHT VENTRICULAR LACERATION DURING PERICARDIAL WINDOW</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c. PERICARDIAL AND EPICARDIAL ADHESIONS WITH LYSIS</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. METASTATIC ADENOCARCINOMA</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RUPTURED HEART	Due to (or as a consequence of):	b. RIGHT VENTRICULAR LACERATION DURING PERICARDIAL WINDOW	Due to (or as a consequence of):	c. PERICARDIAL AND EPICARDIAL ADHESIONS WITH LYSIS	Due to (or as a consequence of):	d. METASTATIC ADENOCARCINOMA	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RUPTURED HEART	Due to (or as a consequence of):														
	b. RIGHT VENTRICULAR LACERATION DURING PERICARDIAL WINDOW	Due to (or as a consequence of):														
	c. PERICARDIAL AND EPICARDIAL ADHESIONS WITH LYSIS	Due to (or as a consequence of):														
	d. METASTATIC ADENOCARCINOMA															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.																
29b. Signature and title of certifier  MD				29c. License number RD # 187229		29d. Date signed (Month, Day, Year) 10/03/2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARD MCCARRON, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237																
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 												

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32159

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Milton D. Pinkney</u>				2. Date of Death Month <u>October</u> Day <u>9</u> Year <u>2000</u>		3. Time of Death <u>4:16 AM</u>		
	4a. Facility Name (If not institution, give street and number) <u>1400 E. Madison Ave. 1007 Apt.</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>		
Funeral Director	5. Social Security Number <u>219-32-1562</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>66</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Feb 17, 1934</u>		
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10. Usual Residence of Decedent 10a. State <u>Maryland</u> 10b. County <u>N/A</u> 10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <u>1</u> Yes <u>2</u> No		10e. Street and Number <u>1400 E. Madison Ave. 1007 Apt.</u>		
10f. Zip Code <u>21205</u>		10g. Citizen of What Country? <u>USA</u>		11. Marital Status <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify: <u>Black</u>	
14. Race - American Indian, Black, White, etc. <u>Black</u>		15. Decedent's Education (Specify only highest grade completed) <u>10</u> Elementary/Secondary (0-12) <u>0</u> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Huckster</u>		16b. Kind of Business/Industry <u>Self employed</u>		17. Father's Name (First, Middle, Last) <u>Milton Pinkney</u>	
18. Mother's Name (First, Middle, Maiden Surname) <u>Marion Johnson</u>		19a. Informant's Name/Relationship (Type, Print) (sister) <u>Mrs. Margaret Burke</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2623 N. Hilton St. Balto, Md. 21216</u>		20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Mt. Zion</u>	
20c. Location - City or Town, State <u>Lansdowne, Md.</u>		21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u>		22. Name and Address of Facility <u>Joseph L. Russ Funeral Home</u> <u>2222 W. North Ave. Balto. Md. 21216</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Common artery disease</u>		Approximate Interval Between Onset and Death	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Brain tumor - resected</u>		23c. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown		24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No		25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No	
26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)		27. Manner of Death <u>1</u> Natural <u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide <u>5</u> Pending Investigation <u>6</u> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>10/16/2000</u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Dr. [Signature]</u>	
29c. License number <u>D 31464</u>		29d. Date signed (Month, Day, Year) <u>10/12/00</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>SHARIP A HASHMI, 821 N. Euston St Suite 308, Balto. MD 21201</u>		31. Date filed (Month, Day, Year) <u>OCT 12 2000</u>		32. Registrar's Signature <u>[Signature]</u>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


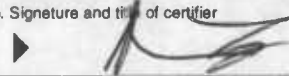
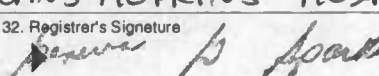
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32160

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOREN PETER SHEIM		2. Date of Death Month: OCTOBER Day: 8 Year: 2000		3. Time of Death 9:30 AM
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA
Funeral Director	5. Social Security Number 205-36-8650	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) October 14, 1945		9. Birthplace (State or Foreign Country) PA		
Usual Residence of Decedent					
10a. State PA		10b. County Lancaster		10c. City, Town or Location Gordonville, PA	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3753 Ridge Road		10f. Zip Code 17562		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Installer		16b. Kind of Business/Industry Kitchen Cabinetry	
17. Father's Name (First, Middle, Last) Oliver Petersheim		18. Mother's Name (First, Middle, Maiden Surname) Ethel Diller			
19a. Informant's Name/Relationship (Type, Print) Anna S. Rank / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3753 Ridge Road, Gordonville PA 17562			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Paradise Mennonite Cemetery		20c. Location - City or Town, State October 11, 2000 Paradise Twp., PA	
21. Signature of Funeral Service Licensed 		22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. CARDIO-RESPIRATORY FAILURE Due to (or as a consequence of): b. ACUTE MYELOID LEUKEMIA Due to (or as a consequence of): c. ASPERGILLOSIS Due to (or as a consequence of): d. PANCYTOPENIA		Approximate Interval Between Onset and Death 48 HOURS 3 MONTHS 5 WEEKS 3 MONTHS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number P9002	
29d. Date signed (Month, Day, Year) OCTOBER 8, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS LYU ; JOHNS HOPKINS HOSPITAL, BALTIMORE, MD					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32161

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>SUMA RAVI PRAKASH</u>				2. Date of Death Month <u>Oct.</u> Day <u>10</u> Year <u>2000</u>		3. Time of Death <u>0545</u>	
	4a. Facility Name (If not institution, give street and number) <u>Howard County General Hospital</u>				4b. City, Town, or Location of Death <u>Columbia, MD</u>		4c. County of Death <u>Howard</u>	
Funeral Director	5. Social Security Number <u>220-43-8952</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>47</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>MAY 19, 1953</u>	
	9. Birthplace (State or Foreign Country) <u>India</u>		10a. State <u>Maryland</u>		10b. County <u>Howard</u>		10c. City, Town or Location <u>Ellicott City</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>3300 Hibiscus Court</u>		10f. Zip Code <u>21043</u>		10g. Citizen of What Country? <u>India</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Asian Indian</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>5+</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Student</u>		16b. Kind of Business/Industry <u>Education</u>			
	17. Father's Name (First, Middle, Last) <u>Mahammed Syeed</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Rukhiya Begum</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Ravi Prakash Gowda/Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3300 Hibiscus Court Ellicott City, MD 21043</u>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory Inc.</u>		20c. Location - City or Town, State <u>10-10-00 Baltimore, MD</u>			
	21. Signature of Funeral Service Licensee <u>Edward A. Grzegorek</u>		22. Name and Address of Facility <u>Cremation Society of MD, Inc.</u> <u>299 Frederick Road Baltimore, MD 21228</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Metastatic Breast carcinoma</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <u>3yrs.</u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred					
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Aheda Ali Khan M.D.</u>		29c. License number <u>D43323</u>		29d. Date signed (Month, Day, Year) <u>Oct. 10, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>10794 Hickory Ridge Road, Columbia, MD, 21044</u>								
State Registrar	31. Date filed (Month, Day, Year) <u>OCT 12 2000</u>		32. Registrar's Signature <u>B. Sparks</u>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32162

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dorothy</i>		2. Date of Death Month <i>October</i> Day <i>09</i> Year <i>2000</i>		3. Time of Death <i>10:00pm</i>
	4a. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Medical Center</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death
Funeral Director	5. Social Security Number <i>218-14-2972</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>78</i> Yrs.	8. Date of Birth Month <i>Dec.</i> Day <i>1</i> Year <i>1921</i>	9. Birthplace (State or Foreign Country) <i>Md.</i>
	Usual Residence of Decedent				
10a. State <i>Md.</i>		10b. County <i>N/A</i>	10c. City, Town or Location <i>Baltimore City</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <i>6425 Danville Ave.</i>			10f. Zip Code <i>21224</i>	10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7 Yrs.</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>	
16b. Kind of Business/Industry <i>Own Home</i>		17. Father's Name (First, Middle, Last) <i>Alexander Nodonly</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Elizabeth Fackett</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Peggy Condon Daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2309 Lodge Farm Rd. Edgemere, Md. 21219</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Oaklawn Cemetery</i>		20c. Location - City or Town, State <i>Dundalk, Md.</i>	
21. Signature of Funeral Service Licensee <i>Anthony Connelly</i>		22. Name and Address of Facility <i>Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <i>STROKE</i> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>4 DAYS</i>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <i>LUNG CANCER</i> Due to (or as a consequence of):		<i>6 months</i>	
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CORONARY ARTERY DISEASE</i>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Patrick O'Connell</i>		29c. License number <i>21012</i>		29d. Date signed (Month, Day, Year) <i>October 9, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Patrick O'Connell MD 7940 Eastern Avenue Baltimore, Maryland 21224</i>					
31. Date filed (Month, Day, Year) <i>OCT 12 2000</i>		32. Registrar's Signature <i>Denise B. Sparks</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-6000.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32163

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERALD CLIFTON ROBINETTE, JR.				2. Date of Death Month Day Year OCTOBER 9, 2000		3. Time of Death 12:25 PM	
	4a. Facility Name (If not institution, give street and number) CLEMENTS STREET				4b. City, Town, or Location of Death BUSHWOOD		4c. County of Death ST. MARY'S	
Funeral Director	5. Social Security Number 230-35-5611		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 27 Yrs.		8. Date of Birth (Month, Day, Year) 10/16/72	
	9. Birthplace (State or Foreign Country) VIRGINIA		10a. State VA		10b. County CHARLOTTE		10c. City, Town or Location DRAKES BRANCH	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 201 C C C ROAD		10f. Zip Code 23937		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10TH GRADE College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OPERATOR		16b. Kind of Business/Industry CONSTRUCTION CO.				
17. Father's Name (First, Middle, Last) GERALD CLIFTON ROBINETTE, SR.				18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY SEAMSTER				
19a. Informant's Name/Relationship (Type, Print) CHRISTY W. ROBINETTE WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 C C C ROAD DRAKES BRANCH, VA 23937				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY GOSPEL CH. CEM.		20c. Date 10/12/2000		20d. Location - City or Town, State DRAKES BRANCH, VA		
21. Signature of Funeral Service Licensee <i>Th. M. King</i>		22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Electrocution</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) scene						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/9/00		28b. Time of Injury 1030 HR		28c. Injury at Work? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred <i>subject of line man in clearing nearby contacted high tension wire</i>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>Cherry picker</i>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>Clements Maryland</i>				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Th. M. King</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 10, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Th. M. King</i> 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature <i>Benjamin B Sparks</i>						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32164

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Anthony Reusing

2. Date of Death

October 11, 2000

3. Time of Death

10:23 AM

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

168-26-1895

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

SEPT 18, 1933

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5968 Autumn Spell

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Counselor

16b. Kind of Business/Industry

Alcohol and Drug

Treatment

17. Father's Name (First, Middle, Last)

John Nicholas Reusing

18. Mother's Name (First, Middle, Maiden Surname)

Sara O'Brien

19a. Informant's Name/Relationship (Type, Print)

Grace E. Reusing/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5968 Autumn Spell Elkridge, MD 21075

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory, Inc.

Date

10/12/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licenses

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. neuro endocrine tumor of pancreas

1 year

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Anthony Reusing, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

October 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Reusing, GARC 6701 N. Charles St. Balto. md 21204

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

10:23 AM

10/11/00

John

Reusing

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Items 26,29d per HOSP,PHY,788,10/12/00dhh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32165

Pl Known as Thomas Reynolds Sr

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Thomas Reynolds Sr.				2. Date of Death Month September Day 25 Year 2000		3. Time of Death 4:45 a.m.	
4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number 212-26-2271		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 1, 1930	
9. Birthplace (State or Foreign Country) South Carolina							
Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Woodlawn			
10e. Street and Number 4 Walden Holly Ct.				10f. Zip Code 21207		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) 8th Grade				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dishwasher		16b. Kind of Business/Industry Woodholme C.C.	
17. Father's Name (First, Middle, Last) Timothy Reynolds				18. Mother's Name (First, Middle, Maiden Surname) Ada Davis			
19a. Informant's Name/Relationship (Type, Print) Juanita Reynolds-daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Walden Holly Ct. Woodlawn, Maryland 21207			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Hill Cemetery		20c. Location - City or Town, State 9-30 Camden, S. Carolina			
21. Signature of Funeral Service Licensee Kevin Parker				22. Name and Address of Facility Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>e. Cardiopulmonary arrest</p> <p>Due to (or as a consequence of):</p> <p>b. Coronary artery disease</p> <p>Due to (or as a consequence of):</p> <p>c. Chronic obstructive pulmonary disease</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> </div>							
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier [Signature]		29c. License number 33039		29d. Date signed (Month, Day, Year) 10/2/00 10/03/00			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Milan WISTER, MD. 6000 Old Court Rd. Suite 301; Baltimore, MD 21208							
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature [Signature]					

Certificate of Death

Reg. No.

00 32166

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARENCE EDWARD RICHARDSON				2. Date of Death Month Day Year OCTOBER 9, 2000		3. Time of Death 1520 PM								
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A								
Funeral Director	5. Social Security Number 214-16-7468		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) 9-17-1919		9. Birthplace (State or Foreign Country) MD.						
	Usual Residence of Decedent				10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 3404 FORREST PARK AVE.												10f. Zip Code 21216		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4 or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER				16b. Kind of Business/Industry ASSEMBLY PLANT							
17. Father's Name (First, Middle, Last) JOHN SKINNER						18. Mother's Name (First, Middle, Maiden Surname) BERTHA RICHARDSON									
19a. Informant's Name/Relationship (Type, Print) NORMAN RICHARDSON (SON)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6615 LAUREL DR. BALTIMORE, MARYLAND 21207									
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE NATIONAL		Date 10-16-2000		20c. Location - City or Town, State BALTIMORE, MARYLAND							
21. Signature of Funeral Service Licensee <i>Gwenivere Redd</i>				22. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Multiple injuries</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month/Day/Year) 10/9/00		28b. Time of Injury 1:25 PM		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>passenger vehicle involved in intersection</i>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>roadway</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>2113 N. W. Forest Park Avenue Baltimore, Maryland</i>											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier <i>Theodore H. King, Jr.</i>				29c. License number OCME				29d. Date signed (Month, Day, Year) OCTOBER 10, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE H. KING, JR.</i> 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature <i>James B. Sparks</i>											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ADH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32167

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cole William Brianhard				2. Date of Death Month Day Year October 04 2000		3. Time of Death 1223	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number NA	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 0 Yrs. 0 Months 0 Days	8. Date of Birth (Month, Day, Year) 12 54 October 3, 2000		9. Birthplace (State or Foreign Country) ()		
	Usual Residence of Decedent							
10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 10321 John Eager Ct.				10f. Zip Code 21042		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NA		16b. Kind of Business/Industry NA		
17. Father's Name (First, Middle, Last) Richard Dane Brianhard				18. Mother's Name (First, Middle, Maiden Surname) Amy Beth Hayter				
19a. Informant's Name/Relationship (Type, Print) Richard Dane Brianhard/father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10321 John Eager Ct. Ellicott City, Md 21042				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ST. JOHNS CEMETERY		20c. Location - City or Town, State Ellicott City, MD		
21. Signature of Funeral Service Licensee Timothy S. [Signature]				22. Name and Address of Facility SLACK FUNERAL HOME P.A. Ellicott City, 21043 3871 Old Columbia Pike				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe Respiratory Distress Syndrome Due to (or as a consequence of): b. Extreme Prematurity Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) NA		28b. Time of Injury NA M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred NA		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) NA		28f. Location (Street and Number or Rural Route Number, City or Town, State) NA		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature] MD				29c. License number D047158		29d. Date signed (Month, Day, Year) October 5, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yann-Yann Lin, M.D.								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637

Wm. J. ...

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32168

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA M. SCHAEFFLER				2. Date of Death Month 10 Day 8 Year 2000		3. Time of Death 10:34 AM	
	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 213-22-6320		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 21, 1928	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD.		10b. County Baltimore		10c. City, Town or Location Baltimore,			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1238 Oakland Terrace Road				10f. Zip Code 21227		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator			16b. Kind of Business/Industry C & P Telephone Co.	
17. Father's Name (First, Middle, Last) Charles Campbell					18. Mother's Name (First, Middle, Maiden Surname) Ivy Plant			
19a. Informant's Name/Relationship (Type, Print) Herman A. Schaeffler-Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1238 Oakland Terrace Road, Baltimore, Maryland 21227			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park			20c. Location - City or Town, State October 11, 2000 Elkridge, Maryland		
21. Signature of Funeral Service Licensee Shanda L Lemmer MD00741				22. Name and Address of Facility Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC PANCREATIC CANCER Due to (or as a consequence of): Approximate Interval Between Onset and Death: 2 months								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D29071		29d. Date signed (Month, Day, Year) 10.9.00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. ANANDA KRISHNAN 824 N. EUTAW ST #305 BALTIMORE MD 21201								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32169

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herbert A. Stran, Sr.				2. Date of Death Month Day Year October 11, 2000		3. Time of Death 4:00 AM	
	4a. Facility Name (If not institution, give street and number) 8606 Cottingham Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-05-2183	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 5, 1919		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8606 Cottingham Road				10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade Collage (1-4or 5+) 				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aerospace Engineer		18b. Kind of Business/Industry Aerospace		
17. Father's Name (First, Middle, Last) Andrew Stran				18. Mother's Name (First, Middle, Maiden Surname) Mertle Meyers				
19a. Informant's Name/Relationship (Type, Print) Herbert A. Stran, Jr. (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7224 Sunshine Ave., Kingsville, MD 21087				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory		Date 10/14/00		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Bruce G. Weller				22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Metastatic Rectal carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Ian K. Slepian				29c. License number D33231		29d. Date signed (Month, Day, Year) 10/11/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Ian K. Slepian, 8817 Belair Rd., Suite 205, Baltimore, MD 21236								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Benny B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32170

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia J. Scott				2. Date of Death Month Day Year October 10 2000				3. Time of Death 0040	
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston				4c. County of Death Harford	
Funeral Director	5. Social Security Number 213-16-4281		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Nov. 8, 1920		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall	
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9903 Fox Hill Road		10f. Zip Code 21128		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) John W. McCartin		18. Mother's Name (First, Middle, Maiden Surname) Lottie V. Sterner		
19a. Informant's Name/Relationship (Type, Print) (Grand- Mrs. Julie McDonnell daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Crabapple Road, Baltimore, MD 21234		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Location - City or Town, State 10/13/00 Baltimore, Maryland		
21. Signature of Funeral Service Licensee Brian C. Lullen		22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. ACUTE RESPIRATORY FAILURE Due to (or as a consequence of): b. IDIOPATHIC PULMONARY FIBROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 DAYS SEVERAL MONTHS		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 10/13/00		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. Ashyankar MD		29c. License number D25027		29d. Date signed (Month, Day, Year) OCTOBER 10, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIJAY M. ABHYANKAR, 2 NORTH AVENUE, BEL AIR MD 21014		
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Sparks								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32171

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lavina Rae Stotelmyer

2. Date of Death

Month Day Year
Oct 08 2000

3. Time of Death

6:25 am

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

177-42-2830

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 20, 1951

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 Winter Street Apt. 1

10f. Zip Code

21740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Bernard A. Peters

18. Mother's Name (First, Middle, Maiden Surname)

Betty L. Coffey

19a. Informant's Name/Relationship (Type, Print)

Judy Harris/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Cross Creek Ct Phoenix, MD 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory, Inc 10/13/00 Beltsville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Laura C. Hordesty

22. Name and Address of Facility

CAFA Stephen D. Lohrmann P.A.
8717 Green Pastures Drive Baltimore, MD 2128623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Cardiac arrest

Approximate
Interval Between
Onset and Death

2 days

Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

Chronic obstructive pulmonary disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid obesity

Chronic renal insufficiency

Diabetes mellitus

Respiratory failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francisco L. Andrade

29c. License number

D27898

29d. Date signed (Month, Day, Year)

Oct 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Francisco L. Andrade, M.D.

1500 Pennsylvania Avenue
Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Francisco L. Andrade

State
Registrar

ORIGINAL

LAVINA R. Stotelmyer
Baltimore, Maryland 21215-0020Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32172

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yvette Marie Stanley				2. Date of Death Month Day Year October 11, 2000		3. Time of Death 1:08 AM		
	4a. Facility Name (If not institution, give street and number) 1818 N. Smallwood St.				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 219-80-9460	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 25, 1961		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 2106 Clifton Ave.			10f. Zip Code 21217		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher's Aide		16b. Kind of Business/Industry Education				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Bernard A. Hopkins				18. Mother's Name (First, Middle, Maiden Surname) Lillian Hawkins				
	19a. Informant's Name/Relationship (Type, Print) (mother) Mrs. Lillian Hopkins				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1818 N. Smallwood St. Balto. Md. 21216				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral		20c. Location - City or Town, State Balto. Md.		20d. Date 10/17/2000		
	21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BREAST CANCER							Approximate Interval Between Onset and Death 3 1/2 YEARS	
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
	Due to (or as a consequence of):								
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MOTHERS HOME						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier [Signature]	
	29c. License number D29071							29d. Date signed (Month, Day, Year) 10.12.00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMANDA KRAIGHAN 821 N. EUTAW ST #305 BALTIMORE MD 21201								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]					

ORIGINAL

— 12.11.1942 —

[Handwritten signature]

Approved for release by the National Security Council on 11/11/1942

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32173

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bettye Delores Spriggs				2. Date of Death Month October Day 10 Year 2000		3. Time of Death 3:35 PM	
	4a. Facility Name (If not institution, give street and number) 4411 Springdale Ave.				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-22-3697	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Sept. 5, 1926	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 4411 Springdale Ave.			10f. Zip Code 21207		10g. Citizen of What Country? USA		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Afro-American	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Assistant U.S. Government			16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) unk.				18. Mother's Name (First, Middle, Maiden Surname) Helen Spriggs			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Joseph Clayton (Brother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4706 Springdale Ave. Balto. Md. 21207				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park		20c. Location - City or Town, State Balto. Md.		20d. Date 10/17/2000	
	21. Signature of Funeral Service Licensee Joseph L. Russ			22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216				
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Metastatic Cancer Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death One month							
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Robert K. Roby				29c. License number 037978		29d. Date signed (Month, Day, Year) October 12, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert K. Roby - MD 2435 W. Belvedere Avenue Baltimore Maryland								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32174

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD SOFTLEY

2. Date of Death
Month Day Year

Oct 9 2000 7:45 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

309-09-2296

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 28, 1910

9. Birthplace (State or Foreign Country)

NEB

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

engineer

16b. Kind of Business/Industry

chemical

17. Father's Name (First, Middle, Last)

Alfred Softley

18. Mother's Name (First, Middle, Maiden Surname)

Cleo P. Fauquet

19a. Informant's Name/Relationship (Type, Print)

Thomas Softley/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

752 Cactus Court Millersville, MD 21108

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year 1

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebro Vascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Name: Howard Softley

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32175

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THERESA E. SNYDER				2. Date of Death Month Day Year OCTOBER 6 2000		3. Time of Death 5:00 AM		
	4a. Facility Name (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 215-03-6926		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) June 22 1913		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County n/a		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 709 Scott Street		10f. Zip Code 21230		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Southern Baking Co.		17. Father's Name (First, Middle, Last) John Yeakel		18. Mother's Name (First, Middle, Maiden Surname) Theresa McEnaney		19. Informant's Name/Relationship (Type, Print) Barbara E. Snyder (Daughter)	
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Date 10/11/2000		20d. Location - City or Town, State Baltimore, Md.		21. Signature of Funeral Service Licensee Christina A. Helton	
22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE RESPIRATORY FAILURE Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TYPE II DIABETES MELLITUS		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/11/2000	
28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dr. Serena R. Nolan		29c. License number D25010		29d. Date signed (Month, Day, Year) 10/6/00		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Serena R. Nolan, M.D. 8831 Satyr Hill Rd., Baltimore, Md. 21234	
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature Sparks		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32176

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SUNANDA SHANTHIKUMAR		2. Date of Death Month Day Year OCTOBER 06, 2000		3. Time of Death 12:15 PM
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY
Funeral Director	5. Social Security Number 214-66-4172	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jan. 06 1930		9. Birthplace (State or Foreign Country) India		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Md.		10b. County Anne Arundel Co.
	10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 6516 Dolphin Court		10f. Zip Code 21061		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Asian
14. Race - American Indian, Black, White, etc. Specify: Asian		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) +6		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator	
16b. Kind of Business/Industry Coppin State		17. Father's Name (First, Middle, Last) Peter Venkiah		18. Mother's Name (First, Middle, Maiden Surname) unknown	
19a. Informant's Name/Relationship (Type, Print) Katta Shanthikumar (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6516 Dolphin Court, Glen Burnie, Md. 21061			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 10/09/2000 Baltimore, Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction		6 hrs		
	Due to (or as a consequence of): Coronary Artery Disease		30 yrs		
	Due to (or as a consequence of): Hypertension		30 yrs		
Due to (or as a consequence of): Diabetes Mellitus		Unknown			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier  MD Resident Physician		29c. License number RES-000		29d. Date signed (Month, Day, Year) 10/6/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Peter Van Doren Johnston MD 600 N. Wolfe St Baltimore, MD 21287					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32177

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Helen Irene Snapp** 2. Date of Death Month **Oct** Day **9** Year **2000** 3. Time of Death **07:45 AM**

4a. Facility Name (If not institution, give street and number) **Howard County General Hospital** 4b. City, Town, or Location of Death **Columbia** 4c. County of Death **Howard**

Funeral
Director

5. Social Security Number **219-28-1313** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **69** Yrs. 8. Date of Birth (Month, Day, Year) **Apr 1, 1931** 9. Birthplace (State or Foreign Country) **Pennsylvania**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Howard** 10c. City, Town or Location **Ellicott City** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **4721 Salterforth Place** 10f. Zip Code **21043** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12)** **College (1-4or 5+)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry **Own Home**

17. Father's Name (First, Middle, Last) **Eli Tschudy** 18. Mother's Name (First, Middle, Maiden Surname) **Helen Leech**

19a. Informant's Name/Relationship (Type, Print) **Susan Vizzini** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4721 Salterforth Place Ellicott City, Maryland 21043**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Lakeview Memorial Park** Date **10/12/00** 20c. Location - City or Town, State **Sykesville, Maryland**

21. Signature of Funeral Service Licensee **Theresa S. Hauer** 22. Name and Address of Facility **Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Intracranial Hemorrhage** **Hypertension** **4 days**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { **Due to (or as a consequence of):** **Due to (or as a consequence of):** **Due to (or as a consequence of):** **Due to (or as a consequence of):**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Stephen Grill** 29c. License number **D41697** 29d. Date signed (Month, Day, Year) **10/11/00**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Stephen Grill, M.D. 11055 Little Patuxent Parkway Columbia, Maryland 21044**

31. Date filed (Month, Day, Year) **OCT 12 2000** 32. Registrar's Signature **Sparks**

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32178

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Raymond Saunders

2. Date of Death

Month Day Year
October 10 2000

3. Time of Death

03:50 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

213-52-1062

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
09/21/1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2809 Georgetown Road

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Production

17. Father's Name (First, Middle, Last)

William Franklin Saunders

18. Mother's Name (First, Middle, Maiden Surname)

Alta Marie Evens

19a. Informant's Name/Relationship (Type, Print)

Martha Jeanette Saunders

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2809 Georgetown Rd. Baltimore, MD. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Meadowridge Memorial Prk.

Date

10/13/00

20c. Location - City or Town, State

Elkridge, Maryland

21. Signature of Funeral Service Licensee

Rebecca Jacobs

22. Name and Address of Facility

Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry RD. Baltimore MD. 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Lung cancer with metastasis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Hwoun Y. Yoo, M.D.

29c. License number

D0053514

29d. Date signed (Month, Day, Year)

October 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hwoun Y. Yoo, M.D., St. Agnes Hospital

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

A Sparks

State
RegistrarGeorge Saunders
Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

NAME
George Saunders
Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32179

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles E. Somers		2. Date of Death Month: Oct Day: 7 Year: 2000		3. Time of Death 1:30 P.M.
	4a. Facility Name (If not institution, give street and number) STAIN AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 219-14-0635	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) May 1, 1923		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 3537 Wilkens Avenue			10f. Zip Code 21229		10g. Citizen of What Country? United States
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofers		16b. Kind of Business/Industry Roofing	
17. Father's Name (First, Middle, Last) Frank C. Somers			18. Mother's Name (First, Middle, Maiden Surname) Eva P. Flack		
19a. Informant's Name/Relationship (Type, Print) Geneva Budney/Friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3537 Wilkens Avenue, Baltimore, Maryland 21229		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 10-12-00 Baltimore, Maryland	
21. Signature of Funeral Service Licensee Lisa S. Jefferson		22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. METASTATIC COLON CANCER			Approximate Interval Between Onset and Death UNKNOWN
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier [Signature] MD		29c. License number P12592		29d. Date signed (Month, Day, Year) OCTOBER 7, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY WILLIAM KAWAUC 800 CATION AVENUE, BALTIMORE					
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature [Signature]			

1972-73

1972-73

1972-73

1972-73

1972-73

X

X

X

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1972-73

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1972-73

1972-73

1972-73

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32180

Certificate of Death

Reg. No.

AMEND#7&

AMEND#8 PER K.B. G788 10-12-2000 JAB

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Salem

2. Date of Death

Month Day Year
SEPTEMBER 2 2000

3. Time of Death

3:45 p.m.

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

Unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
AUGUST 30, 2000

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5332 Eliot's Oak Road

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
N/ACollege (1-4 or 5+)
N/A16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Charity Stone

19a. Informant's Name/Relationship (Type, Print)

Charity Stone/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5332 Eliot's Oak Rd - Columbia, Md. 21044

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Johns Hopkins Hospital 9/3/00 Baltimore, Md

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Nehorah Evans

22. Name and Address of Facility

JHH- 600 N. Wolfe St. 21287

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Extreme Prematurity

75 hours

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Intraparenchymal/Intraventricular Hemorrhage

45 hours

Due to (or as a consequence of):

c. Pulmonary Hemorrhage

45 hours

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

James J. Northington MD

29c. License number

43459

29d. Date signed (Month, Day, Year)

September 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frances J. Northington MD 600 North Wolfe Street Baltimore MD

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Benjamin B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32181

Certificate of Death

Reg. No.

AMENDED ITEM #8 PER FH G788 10/12/00 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAZARZ SONTAG				2. Date of Death Month Day Year OCTOBER 9, 00		3. Time of Death 5:15 PM	
	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER				4b. City, Town, or Location of Death RANDALLSTOWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-64-7871	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN. 12, 1912		9. Birthplace (State or Foreign Country) POLAND
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6905 FIELDCREST ROAD				10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARBER		16b. Kind of Business/Industry TONSorial		
17. Father's Name (First, Middle, Last) SOLOMON				18. Mother's Name (First, Middle, Maiden Surname) SZARLOTTY RISCHLES				
19a. Informant's Name/Relationship (Type, Print) MAREK SONTAG / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5132 WAGON SHED CIRCLE - OWINGS MILLS, MD 21117				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI CEMETERY		20c. Date 10/11/00		20d. Location - City or Town, State OWINGS MILLS, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208				
23a. Part I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier K.S. RAO M.D.				29c. License number 043462		29d. Date signed (Month, Day, Year) OCTOBER 9, 00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S. RAO M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD								
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32182

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY CATHERINE SEBESTA				2. Date of Death Month Day Year OCTOBER 9 2000		3. Time of Death 2:50 am		
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 195074829		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) 10/29/12		
	9. Birthplace (State or Foreign Country) PENNSYLVANIA		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location ROSEDALE		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 821 ROSEDALE AVENUE		10f. Zip Code 21237		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) WILLIS MYERS		18. Mother's Name (First, Middle, Maiden Surname) ALICE (HINKLE)	
19a. Informant's Name/Relationship (Type, Print) PAUL MARTIN SEBESTA (HUSBAND)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 821 ROSEDALE AVENUE ROSEDALE, MD 21237		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH CEM.		20c. Date 10/11/00	
20d. Location - City or Town, State BALTIMORE, MD		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac arrest Due to (or as a consequence of): Diabetes mellitus Due to (or as a consequence of): Hypertension Due to (or as a consequence of): Hypocholesterolemia		Approximate Interval Between Onset and Death >10yrs >10yrs >10yrs	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D30972		29d. Date signed (Month, Day, Year) 10/10/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen K. Garza 4920 Campbell Blvd Baltimore 21236		31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

AH

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32183

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Harold Schwing</u>				2. Date of Death Month <u>October</u> Day <u>4</u> Year <u>2000</u>		3. Time of Death <u>1404</u>	
	4a. Facility Name (If not institution, give street and number) <u>Bayview Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>232-26-8645</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>84</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Oct. 15, 1915</u>	
	9. Birthplace (State or Foreign Country) <u>W.V.</u>		10a. State <u>Md.</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Dundalk</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <u>2902 Dunleer Rd.</u>		10f. Zip Code <u>21222</u>		
10g. Citizen of What Country? <u>USA</u>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 yrs.</u> College (1-4 or 5+) <u>5+</u>		
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Dentist</u>				16b. Kind of Business/Industry <u>Self Employed</u>		17. Father's Name (First, Middle, Last) <u>Mack Schwing</u>		
18. Mother's Name (First, Middle, Maiden Surname) <u>Pauline Burton</u>				19a. Informant's Name/Relationship (Type, Print) <u>Sarah Jane Schwing daughter</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2902 Dunleer Rd. Dundalk Md. 21222</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Bayview Crematory</u>		20c. Location - City or Town, State <u>Baltimore</u>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>Connolly Funeral Home Of Dundalk</u> <u>7110 Sollers Point Rd, 21222</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. pneumonia</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>b. congestive heart failure</u> Due to (or as a consequence of): <u>c. coronary artery disease</u> Due to (or as a consequence of): <u>d.</u>				Approximate Interval Between Onset and Death <u>days</u>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>congestive heart failure</u> <u>coronary artery disease</u>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Antonia Bunce MD</u>		29c. License number <u>20300</u>		
29d. Date signed (Month, Day, Year) <u>October 4, 2000</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Antonia Bunce 4940 Eastern Avenue Baltimore 21224</u>				
31. Date filed (Month, Day, Year) <u>OCT 12 2000</u>				32. Registrar's Signature <u>[Signature]</u>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32184

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE STREETIE				2. Date of Death Month Day Year OCTOBER 9, 2000				3. Time of Death 8:35am			
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS				4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 424-28-1252		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 9-16-1914		9. Birthplace (State or Foreign Country) ALABAMA			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD.		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 18 ROSEMARIE ST.				10f. Zip Code 21401		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4or 5+) -2-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSE			16b. Kind of Business/Industry HEALTHCARE				
	17. Father's Name (First, Middle, Last) BROOKS PERDUE				18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN							
	19a. Informant's Name/Relationship (Type, Print) VIRGINIA WALLACE (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 ROSEMARIE ST. ANNAPOLIS, MARYLAND 21401							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATIONAL		20c. Location - City or Town, State 10-14-2000 LAUREL, MARYLAND					
	21. Signature of Funeral Service Licensee J. D. Hissner				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Diabetes, Hypernatremia, Dehydration UTI Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 1/2	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Hypernatremia, Dehydration UTI										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28d. Describe how injury occurred		
28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29d. Signature and title of certifier J. D. Hissner										29e. License number D32036		
29f. Date signed (Month, Day, Year) 10/09/2000												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gay J. Sprue 2101 D. Parks Drive Chester, MD 21619												
31. Date filed (Month, Day, Year) OCT 12 2000										32. Registrar's Signature Benita B. Sparks		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 32185

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lien Ngoc Tang				2. Date of Death Month October Day 8 Year 2000		3. Time of Death 13:10	
	4a. Facility Name (If not institution, give street and number) Deaton Specialty Hospital and Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 217-11-9289		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 3, 1925	
	9. Birthplace (State or Foreign Country) China		10a. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City	
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code 21043		10g. Citizen of What Country? China	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian	
	17. Father's Name (First, Middle, Last) Ung Tang				18. Mother's Name (First, Middle, Maiden Surname) Muoi Giang			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Thanh Van Loi / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3350 Hollow Court, Ellicott City, Maryland 21043			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Johns Cemetery		Date Oct. 8, 2000		20c. Location - City or Town, State Ellicott City, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anoxic encephalopathy Due to (or as a consequence of): b. Multiple cerebral infarct Due to (or as a consequence of): c. Cardiac arrest Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 month 1 month -			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure, dialysis depend ent Coronary artery disease				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier CPM [Signature]			
	29c. License number 034974				29d. Date signed (Month, Day, Year) Oct. 12th, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CHARA MEHTA, MD, 8775 Cloudcroft, #224, Columbia, MD 21045				31. Date filed (Month, Day, Year) OCT 12 2000			
	32. Registrar's Signature 				33. Registrar's Signature 			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32186

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Rosemary Taylor

2. Date of Death

Month Day Year
October 11 2000

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

18 Archwood Ave.

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

214-38-3218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 24, 1940

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18 Archwood Ave.

10f. Zip Code

21061

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Nora Slaughter

19a. Informant's Name/Relationship (Type, Print)

Ronald L. Taylor, Sr. /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Archwood Ave. Glen Burnie, MD. 21061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metro Crematory

Date

10-13-00

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd.
Arbutus, MD. 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Carcinomatous Meningitis

Approximate
Interval Between
Onset and Death

1 month

Due to (or as a consequence of):

b. Metastatic breast cancer

3 months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D39041

29d. Date signed (Month, Day, Year)

October 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. NIMMAGADDA 3001 S. Hanover Street Baltimore MD 21225

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Anna Rosemary Taylor

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32187

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald R. Thompson				2. Date of Death Month Day Year Oct. 09, 2000		3. Time of Death 8:50pm	
	4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Care				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 213-30-1006		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 08-23-34	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2409 Callow Avenue		10f. Zip Code 21217		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chauffuer		16b. Kind of Business/Industry Baltimore City Water Dept.		17. Father's Name (First, Middle, Last) Raymond Thompson		
18. Mother's Name (First, Middle, Maiden Surname) Geraldine Minor		19a. Informant's Name/Relationship (Type, Print) Gladys L. Thompson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Callow Avenue Baltimore, Maryland 21217		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem.		20c. Location - City or Town, State 10-13-2000 Arbutus, MD		21. Signature of Funeral Service Licensee Gladys W. [Signature]		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. prostate cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 2 years		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier Anthony Riley, MD		29c. License number D25205		29d. Date signed (Month, Day, Year) October 10, 2000		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) W.A. Riley GBMD 6701 N. Charles St. Baltimore		
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature [Signature]		2120x		State Registrar		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32188

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS E. VOLKMAN

2. Date of Death

October 5, 2000

3. Time of Death

9:25 PM

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

220-22-8911

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 8, 1917

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9701 Veirs Drive

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

unk

18a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

clerical

16b. Kind of Business/Industry unk

17. Father's Name (First, Middle, Last)

John Hoefel

18. Mother's Name (First, Middle, Maiden Surname)

Carrie J. Lindeman

19a. Informant's Name/Relationship (Type, Print)

National Lutheran Home

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9701 Veirs Drive Rockville, MD 20850

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e.

Acute respiratory failure

Due to (or as a consequence of):

f.

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

g.

Recurrent pulmonary thromboemboli

Due to (or as a consequence of):

h.

Approximate
Interval Between
Onset and Death

Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

Electrolyte imbalance

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Daniel A. Jaller, MD

29c. License number

D 33138

29d. Date signed (Month, Day, Year)

October 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel A. Jaller, MD 19500 Amaranth Dr, Germantown, MD

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

Denise A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32189

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Mary Vandereedt</u>				2. Date of Death Month <u>October</u> Day <u>10</u> Year <u>2000</u>		3. Time of Death <u>8:55 am</u>	
	4a. Facility Name (If not institution, give street and number) <u>St. Agnes Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>n/a</u>	
Funeral Director	5. Social Security Number <u>051-14-8316</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>96</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Aug. 31 1904</u>	
	9. Birthplace (State or Foreign Country) <u>Ireland</u>		10a. State <u>Md.</u>		10b. County <u>Anne Arundel Co.</u>		10c. City, Town or Location <u>Annapolis</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <u>1159 Neptune Place</u>		10f. Zip Code <u>21401</u>	
	10g. Citizen of What Country? <u>USA</u>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>white</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5</u> College (1-4 or 5+) <u>0</u>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Housewife</u>				16b. Kind of Business/Industry <u>Home Owner</u>		17. Father's Name (First, Middle, Last) <u>Anthony O'Donnell</u>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <u>Beatrice</u>				19a. Informant's Name/Relationship (Type, Print) <u>Arthur J. Van Dereedt (Son)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1159 Neptune Place, Annapolis, Md. 21401</u>	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Green Mount Cemetery</u>		20c. Location - City or Town, State <u>10/12/2000 Baltimore, Md.</u>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>McCully-Polyniak Funeral Home P.A.</u> <u>3204 Mountain Road, Pasadena, Md. 21122</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. pneumonia</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate interval Between Onset and Death <u>hours</u>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>high blood pressure</u> <u>congestive heart failure</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <u>M</u> 28b. Time of Injury <u>1</u> <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>[Signature]</u>			
	29c. License number <u>033061</u>				29d. Date signed (Month, Day, Year) <u>October 10, 2000</u>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Scanning Services 900 Caton Avenue Baltimore</u>				31. Date filed (Month, Day, Year) <u>OCT 12 2000</u>			
	32. Registrar's Signature <u>[Signature]</u>				33. Registrar's Title <u>[Signature]</u>			

12th Nov 1954

Dear Sir,
I have the pleasure to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.
The same has been referred to the appropriate authorities for their consideration.
I am, Sir, very respectfully,
Yours faithfully,
[Signature]

Enclosed for you are two copies of the report of the Committee on the subject of the above matter.
I am, Sir, very respectfully,
Yours faithfully,
[Signature]

X
[Signature]
X
[Signature]
X
[Signature]

Yours faithfully,
[Signature]
cc - Mr. [Name]
cc - Mr. [Name]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32190

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Omar B. Wessel, Sr.				2. Date of Death Month October Day 10 , Year 2000				3. Time of Death 3:15 PM	
	4a. Facility Name (If not institution, give street and number) 4711 Forge Road				4b. City, Town, or Location of Death Perry Hall				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-14-0002		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) May 23, 1924		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4711 Forge Road				10f. Zip Code 21128		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) 				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Firefighter-Captain				16b. Kind of Business/Industry Baltimore City Fire Department	
	17. Father's Name (First, Middle, Last) Charles Wessel				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Brown					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Mr. Dennis M. Wessel (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14009 Manor Road, Baldwin, MD 21013					
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date 10/14/00		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. BLADDER a. METASTATIC TRANSITIONAL CELL CARCINOMA - 1 YEAR Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	23b. Old tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 				29c. License number D31775			29d. Date signed (Month, Day, Year) OCTOBER 11, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOAN P EDWARDS MD 2112 BELAIR RD FAULSTON MD. 21047										
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony Lee Ward

2. Date of Death

Month

Day

Year

SEPTEMBER 28, 2000

3. Time of Death

1858 PM

4a. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral
Director

5. Social Security Number

213-64-5631

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

45

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 16, 1955

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

2222 Division St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Orlander Ward

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Ward

19a. Informant's Name/Relationship (Type, Print) (wife)

Mrs. Wanda Ward

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2222 Division St. Balto. Md. 21217

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion

Date

10/14/2000

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto. Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural
20 Accident
30 Suicide
40 Homicide50 Pending
Investigation
60 Could not be
determined

28a. Date of Injury

found: 9/28/00

28b. Time of
injury

found: 6:00

P

M

28c. Injury at
Work?

10 Yes 20 No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)
found at home28f. Location (Street and Number or Rural Route Number,
City or Town, State) 2222 Division St.,
Balto. City, Md.29a. Certifier
(Check only
one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Joseph Pestaner, M.D.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

SEPTEMBER 29, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

OCT 12 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e show
any injury or other traumatic event, the Medical Examiner must be notified at
0055.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32192

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise G. Williams				2. Date of Death Month Day Year Oct. 06, 2000		3. Time of Death 5:00am		
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care Perring Parkway				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA		
Funeral Director	5. Social Security Number 219-10-8226		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75	8. Date of Birth (Month, Day, Year) 09-30-25		9. Birthplace (State or Foreign Country) SC		
	Usual Residence of Decedent								
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3337 Clifftmont Avenue				10f. Zip Code 21213		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High Sch. Grad College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nursing Assistant		16b. Kind of Business/Industry Johns Hopkins Hosp.			
17. Father's Name (First, Middle, Last) David Grant				18. Mother's Name (First, Middle, Maiden Surname) Narcissus McCullers					
19a. Informant's Name/Relationship (Type, Print) David G. Eley				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3337 Clifftmont Avenue Baltimore, MD. 21213					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem.		20c. Location - City or Town, State MD		20d. Location - City or Town, State 10-13-2000 Owings Mill			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue					
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHF Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Annie Demerit								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier MARTHA C. RAUMUNDO MD		29c. License number 054518		29d. Date signed (Month, Day, Year) 10/9/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTHA C. RAUMUNDO 3007 E. Northern Parkway Baltimore MD 21214									
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature <i>[Signature]</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32193

AMEND ITEM #10c PER FH G788 10/12/00 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANOR WEISSMAN		2. Date of Death Month Day Year OCTOBER 9, 2000		3. Time of Death 2:10 PM						
	4a. Facility Name (If not institution, give street and number) JEWISH CONVALESCENT CENTER & NURSING HOME		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE						
Funeral Director	5. Social Security Number 215-01-8162	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) MAY 21, 1909		9. Birthplace (State or Foreign Country) MD								
Usual Residence of Decedent											
10a. State MD		10b. County N/A		10c. City, Town or Location 3601 FORDS LANE #806 BALTIMORE							
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
10e. Street and Number 3601 FORDS LANE #806		10f. Zip Code 21215		10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: WHITE											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) // College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry OWN HOME							
17. Father's Name (First, Middle, Last) JACOB		18. Mother's Name (First, Middle, Maiden Surname) OSCHEROFF BESSIE KUPERSMIDT									
19a. Informant's Name/Relationship (Type, Print) FRANCES WEIL / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6511 WICKFIELD ROAD - BALTIMORE, MD 21209									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HAR SINAI CEMETERY		20c. Location - City or Town, State 10/11/00 OWINGS MILLS, MD							
21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>		22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. End Stage Dementia</td> <td rowspan="4">Approximate Interval Between Onset and Death Unknown</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End Stage Dementia	Approximate Interval Between Onset and Death Unknown	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. End Stage Dementia	Approximate Interval Between Onset and Death Unknown									
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration Arrival Feb											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M							
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Meert MD</i>		29c. License number 027569		29d. Date signed (Month, Day, Year) 10/10/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Kettleman 1838 Greene Tree Rd #300											
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature <i>Sparks</i>									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32194

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward J. Wellner				2. Date of Death Month Day Year October 5 2000		3. Time of Death 11:15 AM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice at Mercy Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-01-7587		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) June 28 1906	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8430 Mitzy Lane		10f. Zip Code 21043		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector		16b. Kind of Business/Industry Automotive			
	17. Father's Name (First, Middle, Last) Frank Wellner				18. Mother's Name (First, Middle, Maiden Surname) Antonia Paul			
	19a. Informant's Name/Relationship (Type, Print) Susan Gershman/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8430 Mitzy Lane, Ellicott City MD 21043			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		20c. Date 10-7-00		20d. Location - City or Town, State Baltimore MD	
	21. Signature of Funeral Home Licensee 				22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237			
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Renal Failure Due to (or as a consequence of): b. Dehydration Due to (or as a consequence of): c. CVA Due to (or as a consequence of): d. Intracranial Bleed							
	Approximate Interval Between Onset and Death 3d 7d 2 weeks 3 weeks							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HTN, Gout							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of Certifier 				29c. License number D42908		29d. Date signed (Month, Day, Year) 10/6/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Scharf MD 808 S. Linking Street Balt. MD 21224								
31. Date filed (Month, Day, Year) OCT 12 2000								
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32195

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEBORAH LYNN WHEATON				2. Date of Death Month Day Year October 5 2000		3. Time of Death 600 pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-74-1026	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 24, 1955		9. Birthplace (State or Foreign Country) DC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 114 Mace Avenue			10f. Zip Code 21221		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) press operator			16b. Kind of Business/Industry canning		
	17. Father's Name (First, Middle, Last) Alvin W. Wheaton				18. Mother's Name (First, Middle, Maiden Surname) Kathryn Sherman			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carol Palmerton/friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8320 Harrison Blvd Chesapeake Beach, MD 20732			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Approximate Interval Between Onset and Death							
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Metastatic Colon Cancer				2 years			
	Due to (or as a consequence of):							
	b. Due to (or as a consequence of):							
	c. Due to (or as a consequence of):							
	d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute renal failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury of Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Carol Newill MD				29c. License number D44717		29d. Date signed (Month, Day, Year) 10/8/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol Newill MD, 9000 Franklin Square Drive Baltimore Maryland 21237								
State Registrar	31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature B. Sparks			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32196

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARTHUR J. WHALLEY				2. Date of Death Month Day Year October 6 2000		3. Time of Death 0140	
	4a. Facility Name (If not institution, give street and number) FALLSTON GENERAL HOSPITAL				4b. City, Town, or Location of Death FALLSTON		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 215-28-6775	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-1-1931	9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location EDGEWOOD			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 1224 CHIPPER DRIVE			10f. Zip Code 21040		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: KOREAN		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COMPUTER DEPARTMENT		16b. Kind of Business/Industry U.S. GOVERNMENT DEFENSE			
	17. Father's Name (First, Middle, Last) ARTHUR WHALLEY				18. Mother's Name (First, Middle, Maiden Surname) MILDRED (LETSCHIN)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) STEVEN WHALLEY (SON)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 CHIPPER DRIVE EDGEWOOD, MD 21040				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HOLLY HILL CEMETERY		Date 10-9-00	20c. Location - City or Town, State BALTIMORE, MD		
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urosepsis Hypotension							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 			29c. License number 037612		29d. Date signed (Month, Day, Year) 10/7/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohamad Alabrash, MD 1201 Agora Drive #2C Bel Air, Maryland 21014							
State Registrar	31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature 					

ORIGINAL


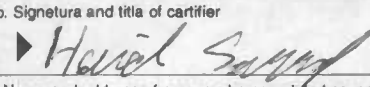
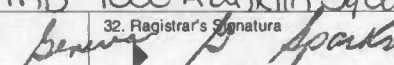
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32197

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Willie Thomas Yarborough				2. Date of Death Month Day Year October 3 2000		3. Time of Death 1:15pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 245-68-5253		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) 03-12-45	
	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 6064 Marquette Road				10f. Zip Code 21206		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry General Motors	
17. Father's Name (First, Middle, Last) Lorenzo Yarborough					18. Mother's Name (First, Middle, Maiden Surname) Rosa Yarborough			
19a. Informant's Name/Relationship (Type, Print) Dorothea Holmes				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3738 Ellerslie Avenue Baltimore, Maryland 21218				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest VA Cem. 10-13-2000 Owings Mills			20c. Location - City or Town, State MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intracranial Bleeding Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  MD				29c. License number 203307		29d. Date signed (Month, Day, Year) 10-3-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haider Sarraf MD 9000 Franklin Square Drive Baltimore Maryland 21237								
31. Date filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32198

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Owen McClintick Akers				2. Date of Death Month Day Year SEPTEMBER 27, 2000		3. Time of Death 01:03 A.M.	
	4a. Facility Name (If not institution, give street and number) MALCOLM GROW MEDICAL CENTER				4b. City, Town, or Location of Death CAMP SPRINGS		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 710 14 9259		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct 26, 1915	9. Birthplace (State or Foreign Country) Kansas
	Usual Residence of Decedent							
10a. State MD		10b. County P.G.		10c. City, Town or Location Temple Hills			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6305 Mark Drive				10f. Zip Code 20748		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Navigational Scientist			16b. Kind of Business/Industry U.S. Government	
17. Father's Name (First, Middle, Last) J.G. Akers					18. Mother's Name (First, Middle, Maiden Surname) Belle (UNKNOWN)			
19a. Informant's Name/Relationship (Type, Print) Patricia A. Carlson/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Urbana Drive, Wheaton, Maryland 20906			
20a. Method of Disposition: 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory Sept 29, 2000		20c. Location - City or Town, State Clinton, Maryland		
21. Signature of Funeral Service Licensee					22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735			
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEPSIS-UNCLEAR ETIOLOGY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 5 DAYS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD AIFIS						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier					29c. License number ME 70064		29d. Date signed (Month, Day, Year) SEPTEMBER 27, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEDRO A. ALONSO, MAJ, USAF, MD					89 MDG/1050 W. PERIMETER RD. ANDREWS AIR FORCE BASE, MD 20762-6600			
31. Date filed (Month, Day, Year) SEP 29 2000					32. Registrar's Signature S. G. Sparks			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: OWEN M. AKERS

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32199

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CELESTE ANGELA ARNOLD

2. Date of Death

Month Day Year
SEPTEMBER 21 2000

3. Time of Death

8:25 A.M.

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

216-38-4965

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 24, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

118 Arundel Beach Road

10f. Zip Code

21147

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

John Thomas White

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ethel Kohlhaus

19a. Informant's Name/Relationship (Type, Print)

Carole A. Nusbaum/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

331 Sturtons Lane, Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

9/26

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

Robert A. Myers

22. Name and Address of Facility

Myers Funeral Home
91 Willis Street
Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

PNEUMONIA

Due to (or as a consequence of):

b.

SEPSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert A. Myers M.D.

29c. License number

D43977

29d. Date signed (Month, Day, Year)

September 21 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arthur Dietzinger, 301 Hospital Drive, Glen Burnie, MD 21061

31. Date filled (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Brenda B. Sparks

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CELESTE ARNOLD
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

MA 2012 10/10/12

03/21/13

2012

10/10/12

2012

10/10/12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32200

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melvin Gray Alderman				2. Date of Death Month Day Year OCTOBER 1, 2000		3. Time of Death 12:25 PM		
	4a. Facility Name (If not institution, give street and number) EASTBOUND CHARLES STREET EAST OF FARM ROAD				4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES		
Funeral Director	5. Social Security Number 217-20-0734		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) 6/1/1926		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Virginia		10b. County N/A		10c. City, Town or Location Newport News		
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 7303 Roanoke Avenue		10f. Zip Code 23605		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 22		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Instructor/Trainer		16b. Kind of Business/Industry Civil Service					
17. Father's Name (First, Middle, Last) James Albert Alderman				18. Mother's Name (First, Middle, Maiden Surname) Shrilda Narcissus Keen					
19a. Informant's Name/Relationship (Type, Print) Cindy A. Brown, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Mayflower Drive, Portsmouth, Va. 23701					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Peninsula Funeral Home Crematorium		Date 10/4/00		20c. Location - City or Town, State Newport News, Va.			
21. Signature of Funeral Service Licensee <i>Danny H. Babin</i>		22. Name and Address of Facility Peninsula Funeral Home, Inc. 11144 Warwick Boulevard Newport News, Va. 23601							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/01/00		28b. Time of Injury 1220 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred vehicle in road subject driving accident in vehicle		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway							
28f. Location (Street and Number or Rural Route Number, City or Town, State) Eastbound Charles Street east of Farm Road Charles County Maryland									
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Thorburn M. King</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 2, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) OCT 12 2000		32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32201

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Irene Alderman				2. Date of Death Month Day Year October 1 2000		3. Time of Death 1353		
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Chesley		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 214-28-2522		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) 10/7/1931		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Virginia 10b. County N/A 10c. City, Town or Location Newport News 10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Bus Driver		16b. Kind of Business/Industry City of Newport News	
17. Father's Name (First, Middle, Last) George W. Shelton				18. Mother's Name (First, Middle, Maiden Summa) Elizabeth Catherine Weeks				19a. Informant's Name/Relationship (Type, Print) Cindy A. Brown, daughter	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Mayflower Drive, Portsmouth, Va. 23701				20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Peninsula Funeral Home Crematorium		20c. Location - City or Town, State 10/5/00 Newport News, Va.	
21. Signature of Funeral Service Licensee Danny G. Beltz				22. Name and Address of Facility Peninsula Funeral Home, Inc. 11144 Warwick Boulevard Newport News, Va. 23601				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Motor Vehicle Accident with multiple injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year) October 1, 2000				28b. Time of Injury 12:20 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Patient was front-seat, belted passenger in head on collision	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 6, West of Penns Hill Road, Charles County Maryland				29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier Salvador S. Sylvester, DO				29c. License number H0055927		29d. Date signed (Month, Day, Year) October 2, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salvador S. Sylvester 309 Hospital Drive, Chesley, Maryland 20785				31. Data filed (Month, Day, Year) OCT 12 2000				32. Registrar's Signature [Signature]	

Baltimore, Maryland 21215-0020

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

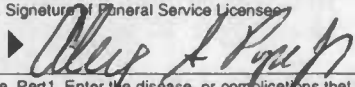
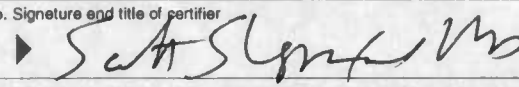
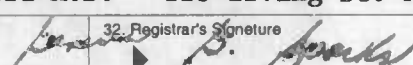
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32202

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH BRANDON				2. Date of Death Month Day Year SEPT. 20, 2000				3. Time of Death 1:00 P.M.					
	4a. Facility Name (If not institution, give street and number) 6820 Parkwood Street				4b. City, Town, or Location of Death Landover Hills				4c. County of Death Prince Georges					
Funeral Director	5. Social Security Number 229-12-8423		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 9/17/1919		9. Birthplace (State or Foreign Country) Pittsylvania Cty VA	
	Usual Residence of Decedent													
10e. State D.C.		10b. County		10c. City, Town or Location Washington						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number 2101 I Street NE						10f. Zip Code 20002				10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver				16b. Kind of Business/Industry Private				
17. Father's Name (First, Middle, Last) Joe Fitzgerald						18. Mother's Name (First, Middle, Maiden Surname) Edna Brandon								
19a. Informant's Name/Relationship (Type, Print) Dee L. Brandon Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2101 I Street NE, Washington, DC 20002								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hill Cemetery				Data 9/25/2000		20c. Location - City or Town, State Clinton, MD				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md. 20747								
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renal Cancer a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Granddaughter's house								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 						29c. License number #19404		29d. Date signed (Month, Day, Year) September 22, 2000						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Scott Sheppard M.D. 110 Irving St. N.W. S-A/50 Washington, D.C. 20010														
31. Date filed (Month, Day, Year) SEP 26 2000						32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32203

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilson V. Banks				2. Date of Death Month Day Year 09 24 2000		3. Time of Death 9 ⁵⁵ PM		
	4a. Facility Name (If not institution, give street and number) Cherry Lane Nursing Center				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 577-16-0171		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 12, 1905		
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Glenarden		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1420 - 7th Street		10f. Zip Code 20706		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Self-Employed				
	17. Father's Name (First, Middle, Last) William Banks		18. Mother's Name (First, Middle, Maiden Surname) Nora Brooks						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charles F. Minor, Sr. - Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 - 7th Street, Glenarden, MD 20706				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, MD		20d. Date 9/29/2000		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee John T. Stewart, III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Organic Brain Syndrome							Approximate Interval Between Onset and Death 10 days	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John N. Margolis, MD		29c. License number D002543D		29d. Date signed (Month, Day, Year) 9/27/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Margolis, MD 13952 Baltimore Ave. Laurel, MD 20707								
State Registrar	31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32204

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM BODDIE		2. Date of Death Month September Day 23 Year 2000		3. Time of Death 9:10 PM
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 579-03-3627	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
	8. Date of Birth (Month, Day, Year) June 16, 1914		9. Birthplace (State or Foreign Country) North Carolina		
Usual Residence of Decedent					
10a. State D.C.		10b. County N/A		10c. City, Town or Location Washington	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 257 Rock Creek Church Rd N.W.			10f. Zip Code 20011		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs.		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supv.		16b. Kind of Business/Industry National Capitol Housing Authority	
17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (First, Middle, Maiden Surname) Fannie Boddie		
19a. Informant's Name/Relationship (Type, Print) Verna B. Drumming - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4422 2nd Street N.E., Washington DC 20011		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State 9-30-2000 Landover, Maryland	
21. Signature of Funeral Service Licensee Julia P. Marshall		22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011			
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. CARCINOMA OF COLON WITH METASTASIS					Approximate Interval Between Onset and Death
23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. b. Due to (or as a consequence of):					
23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. c. Due to (or as a consequence of):					
23d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Septicemia with Staphylococcus Epidemicus ② Aspiration Pneumonia with Methicillin Resistant Staphylococcus Aureus ③ Urinary Tract Infection with Pseudomonas Aeruginosa ④ Coronary Artery Disease ⑤ Atherosclerosis ⑥ Diabetes Mellitus ⑦ Anemia					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury 1 Yes <input type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Mohammed A. Mannan MD		29c. License number D24593		29d. Date signed (Month, Day, Year) 9.23.00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED A. MANNAN MD 3331- TOLEDO TERRACE HYATTSVILLE, MD. 20782					
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32205

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marvin Albert Boettcher				2. Date of Death Month Sept Day 24 , Year 2000		3. Time of Death 5:30 AM	
	4a. Facility Name (If not Institution, give street and number) Spring Brooke Nursing Home				4b. City, Town, or Location of Death Silver Spring,		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 477 16 1870		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 23, 1922	9. Birthplace (State or Foreign Country) Minn.
	Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3622 Gleneagles Drive				10f. Zip Code 20906		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WW II If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Civil Service Comm.		
17. Father's Name (First, Middle, Last) Theodore Boettcher				18. Mother's Name (First, Middle, Maiden Surname) Henrietta Doering				
19a. Informant's Name/Relationship (Type, Print) Heidi De Concini (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10927 Rocky Mount Way, Silver Spring, MD 20902				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Sept 28, 2000 Clinton, Maryland		
21. Signature of Funeral Service Licensee St G. Sitt				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death > 1 yr.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vertebral osteomyelitis, Infected Dialysis Access Site, Atrial Fibrillation, Stroke								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier St G. Sitt MD		29c. License number D31001		29d. Date signed (Month, Day, Year) 9/26/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stuart Turkewitz, M.D. 7500 Greenway Center #430, Greenbelt, Maryland								
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32206

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Freda A. Booker				2. Date of Death Month 9 Day 22 Year 2000		3. Time of Death 2:30p	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death mont.	
Funeral Director	5. Social Security Number 102 12 6998	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) 1 30 20	9. Birthplace (State or Foreign Country) Ala.			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County mont.	10c. City, Town or Location Silver Spring			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 9039 Sligo Creek Pkwy			10f. Zip Code 20901		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black.	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12yrs College (1-4 or 5+) 1yr.		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		16b. Kind of Business/Industry BEAUTY			
	17. Father's Name (First, Middle, Last) John Moore				18. Mother's Name (First, Middle, Maiden Surname) Josephine Rainer			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Edward Moore / Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 689 Aline Dr. Atlanta Ga. 30318			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Wash. Cem.		20c. Location - City or Town, State Adelphi, MD.		20d. Date 9-28-00	
	21. Signature of Funeral Service Licensee Juan Smith		22. Name and Address of Facility John T. Rhines Company		22b. Address 3015-12th St. NE Wash DC 20017			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Wheezing Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last metastatic carcinoma of Breast Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Myron L. Lenkin MD				29c. License number 406674		29d. Date signed (Month, Day, Year) 9/25/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MYRON L. LENKIN MD				2309 SHOREVIEW RD WASHINGTON MD 20902				
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and mostly illegible due to the quality of the scan and the nature of the bleed-through.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32207

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RAYMOND BOLDEN				2. Date of Death Month Day Year SEPT 25 2000		3. Time of Death 1052	
	4a. Facility Name (If not institution, give street and number) MERCY HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 231-78-5598		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) June 17, 1952	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Virginia		10b. County Richmond		10c. City, Town or Location Richmond	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 1923 Lakeview Ave.			
	10f. Zip Code 23220				10g. Citizen of What Country? United States			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baggage Handler		16b. Kind of Business/Industry Greyhound Bus Co.			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Raymond Anderson				18. Mother's Name (First, Middle, Maiden Surname) Blanche Ellis			
	19a. Informant's Name/Relationship (Type, Print) Rose Anderson/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Apt. D. Dove St. Richmond, Va. 23222			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Roselawn Mem. Garden		20c. Date 10/4/00		20d. Location - City or Town, State Richmond, Va.	
	21. Signature of Funeral Service Licensee Ruth A. Moore		22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Poorly Differentiated Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death 4 Months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Joseph Costa, MD		29c. License number D42434		29d. Date signed (Month, Day, Year) SEPT 25, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH COSTA, MD 301 ST PAUL PLACE BALTIMORE MD 21202							
	31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32208

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Delores Edmonia Borders				2. Date of Death Month Day Year September 25 2000		3. Time of Death 3:27 PM	
	4a. Facility Name (If not institution, give street and number) Doctors Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-58-9448		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 30, 1939	
	9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Greenbelt	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Greenbelt	
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 6205 Springhill Drive #201		10f. Zip Code 20770	
To Be Completed by Physician/Medical Examiner	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)	
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Aide				16b. Kind of Business/Industry Government		17. Father's Name (First, Middle, Last) Adolph Trent	
	18. Mother's Name (First, Middle, Maiden Surname) Hattie Dade				19a. Informant's Name/Relationship (Type, Print) Anthony Littleford - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Elfin Ave., Capitol Heights, MD 20743	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 9/30/2000 Suitland, MD	
	21. Signature of Funeral Service Licensee John T. Stewart, III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Myelogenous Leukemia Due to (or as a consequence of):				Approximate Interval Between Onset and Death 5 yrs			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier R. G. Bhojraj MD				29c. License number D 23181		29d. Date signed (Month, Day, Year) 9-26-2000	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) R. G. BHOJRAJ, M.D. 704 GORMAN AVE #T-1 LAUREL, MD 20707				31. Date filed (Month, Day, Year) SEP 28 2000			
	32. Registrar's Signature P. Sparks							

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State of Maryland / Department of Health and Mental Hygiene

00 32209

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Celestina Blackellar				2. Date of Death Month Day Year Sept. 25, 2000				3. Time of Death 8:00AM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 578-06-8949		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 5/4/03		9. Birthplace (State or Foreign Country) Jamaica		Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State MD		10b. County Prince Georges		10c. City, Town or Location Hyattsville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 5815 Maryhurst Dr.				10f. Zip Code 20782		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic	
	17. Father's Name (First, Middle, Last) James Scott				18. Mother's Name (First, Middle, Maiden Surname) Wilhemina Grant					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Utilia Blackellar				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5815 Maryhurst Dr., Hyattsville, MD 20782					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rockcreek Cemetery		Date Sep 30, 00		20c. Location - City or Town, State Washington, DC			
	21. Signature of Funeral Service Licensee <i>Betha Jenkins</i>				22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St., NW Washington, DC 20011					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Respiratory Failure</i> Due to (or as a consequence of): b. <i>pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>SEPSIS</i> <i>Acute Renal Failure</i> <i>Failure to Thrive</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 42403		29d. Date signed (Month, Day, Year) 9/25/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Raj Mathur 106 Irving St NW, Washington DC 20010</i>		31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32210

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAYFIELD

BENNETT

2. Date of Death

Month Day Year
SEPTEMBER 26, 2000 7 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

MANOR CARE HEALTH

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONT

5. Social Security Number

240-46-8236

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
4/13/04

9. Birthplace (State or Foreign

Country)
NEW LONDON, NC

Usual Residence of Decedent

10a. State

DC

10b. County

N/A

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

635 EDGEWOOD ST NE #227

10f. Zip Code

20017

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8TH GRADECollege (1-4 or 5+)
NONE16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL J. WALKER

18. Mother's Name (First, Middle, Maiden Surname)

PATTY KEARNS

19a. Informant's Name/Relationship (Type, Print)

CLARENCE RICE (GRANDSON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6622 7TH PLACE NW, DC 20011

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GLENWOOD CEMETERY

Date

9-30-00 WASHINGTON, D.C.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Long Island

22. Name and Address of Facility

JOHN T. RHINES CO., INC.
3030 12TH ST NE, DC 2001723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)e. ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

ACUTE

Sequitely list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. CORONARY ARTERY DISEASE
Due to (or as a consequence of):

YEARS

c. HYPERTENSION
Due to (or as a consequence of):

YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Robert M. Magin, MD

29c. License number

D25422

29d. Date signed (Month, Day, Year)

SEPTEMBER 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT MAGIN, MD 13952 ROUTINE AVE, LAUREL, MARYLAND 20707

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32211

AMENDED # 5. P.G. GC, 9/27/00 amend item 2 per md G789 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Emory Brennan		2. Date of Death Month September Day 20 Year 2000		3. Time of Death 12:20 am
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 218-30-3596	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) May 7, 1909		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10e. State Maryland		10b. County Prince George's		10c. City, Town or Location Riverdale	
10f. Zip Code 20737		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Piano Teacher		16b. Kind of Business/Industry Self Employed	
17. Father's Name (First, Middle, Last) Robert Emmett Brennan			18. Mother's Name (First, Middle, Maiden Surname) Ethel Corinne Reese		
19a. Informant's Name/Relationship (Type, Print) Lawrence E. Brennan - Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Norman Ridge Drive, Bloomington, MN 55437		
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 9/23/2000 Alexandria, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		e. SEPSIS Due to (or as a consequence of):		Approximate Interval Between Onset and Death ~ 1 day	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. ASPIRATION PNEUMONIA Due to (or as a consequence of):		~ 1 day	
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D-17874		29d. Date signed (Month, Day, Year) September 22, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANKARAN M. NAYAR, MD 3717-38th NE, COTTAGE CITY, MD 20722					
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32212

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHELIA ANN BRIESKE				2. Date of Death Month Day Year SEPTEMBER 23, 2000				3. Time of Death 7:25AM	
	4a. Facility Name (If not institution, give street and number) National Institute of Health				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 558-49-7441		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 9, 1961		9. Birthplace (State or Foreign Country) Iowa	
	Usual Residence of Decedent 10a. State South Carolina 10b. County Greenville 10c. City, Town or Location Greenville 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number P. O. Box 614 10f. Zip Code 29602 10g. Citizen of What Country? U.S.A.					
To Be Completed by Funeral Director	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/President		16b. Kind of Business/Industry New Line Services					
	17. Father's Name (First, Middle, Last) Paul Bernard Brieske				18. Mother's Name (First, Middle, Maiden Surname) Ann (unknown)					
	19a. Informant's Name/Relationship (Type, Print) Ann Brieske - Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 267 Datura Street, Henderson, NV 89014					
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mackey Mortuary		Date 9/25/00		20c. Location - City or Town, State Greenville, S.C.			
	21. Signature of Funeral Service Licensee J P Marshall		22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 8th Street N.W., Washington, DC 20011							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ADULT RESPIRATORY DISTRESS Syndrome WEEK Due to (or as a consequence of): b. METASTATIC ANGIOSARCOMA MONTH Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J P Marshall MD		29c. License number ME 65981		29d. Date signed (Month, Day, Year) 9/23/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEBBIE PAUL MURPHY MD		31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature B. Sparks				
State Registrar										

Baltimore, Maryland 21215-0020

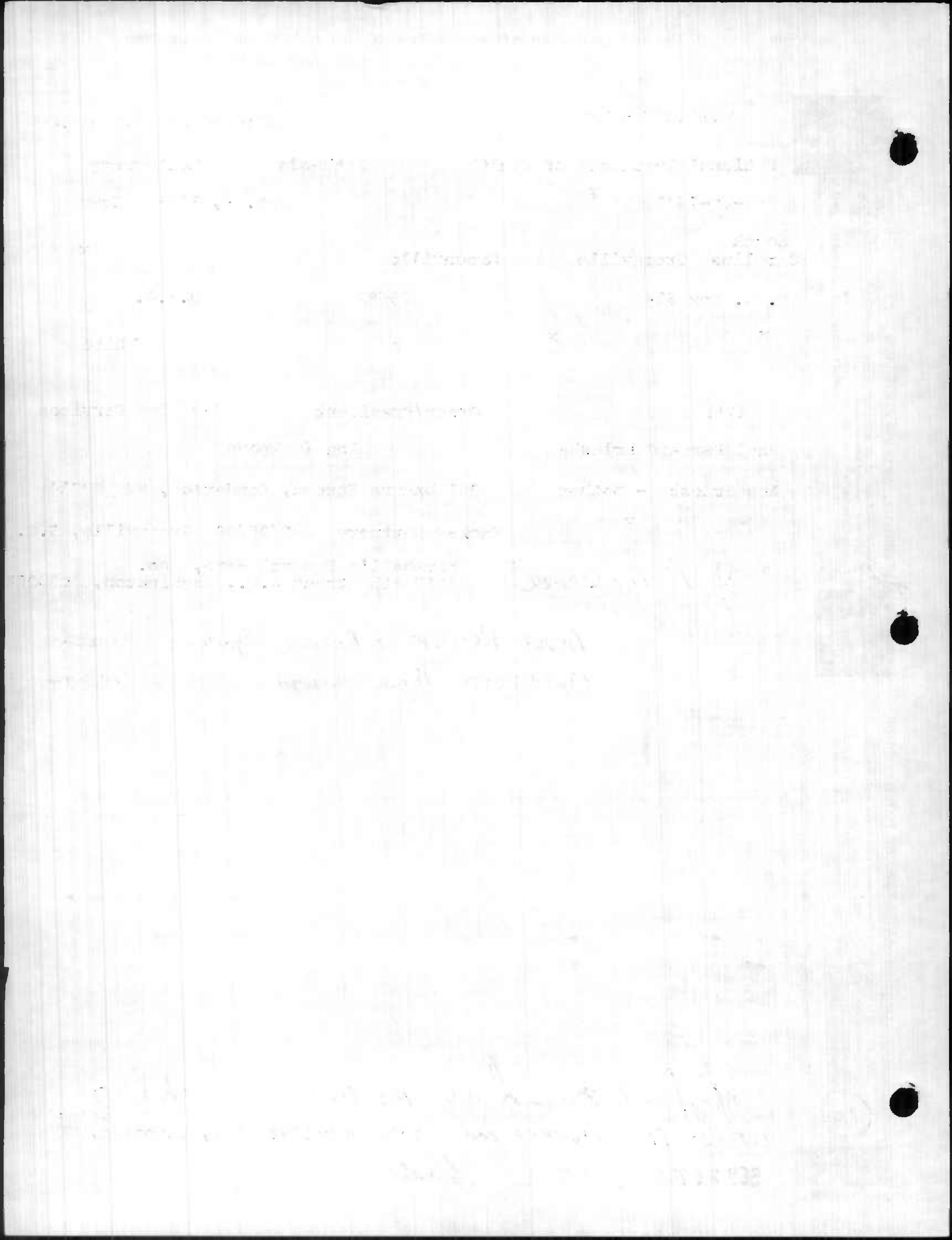
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herman Morris Baylor, Jr.				2. Date of Death Month 09 Day 23 Year 2000		3. Time of Death 10:03 AM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton,		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 577-42-0954		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 15, 1930	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
10a. State MD		10b. County Prince George		10c. City, Town or Location Clinton			10d. Inside City Limits X Yes 2 No	
10e. Street and Number 9106 Pineview Lane				10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6+ College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Principal		16b. Kind of Business/Industry Government		
17. Father's Name (First, Middle, Last) Herman Morris Baylor, Sr.				18. Mother's Name (First, Middle, Maiden Summa) Geraldine Amelia Mason				
19a. Informant's Name/Relationship (Type, Print) Joan Baylor Former wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6316 Walton Avenue, Camp Springs, MD 20746				
20a. Method of Disposition X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		Date 09/30/00		20c. Location - City or Town, State Washington, DC		
21. Signature of Funeral Service Licensee <i>Shelton W. Hackett Sr.</i>				22. Name and Address of Facility Bianchi Funeral Service 814 Upshur ST NW, Wash, DC 20011				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSTIS Due to (or as a consequence of): b. Decubitus ulcers Due to (or as a consequence of): c. Diabetes Mellitus type I Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 1 week 1 month
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal disease on Dialysis Hypertension Atherosclerotic Cardiovascular disease						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Raymond Surana</i>				29c. License number D50653		29d. Date signed (Month, Day, Year) 9-23-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN-C. SURANA 5851 Dealechurinton Road Deale MD 20751								
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

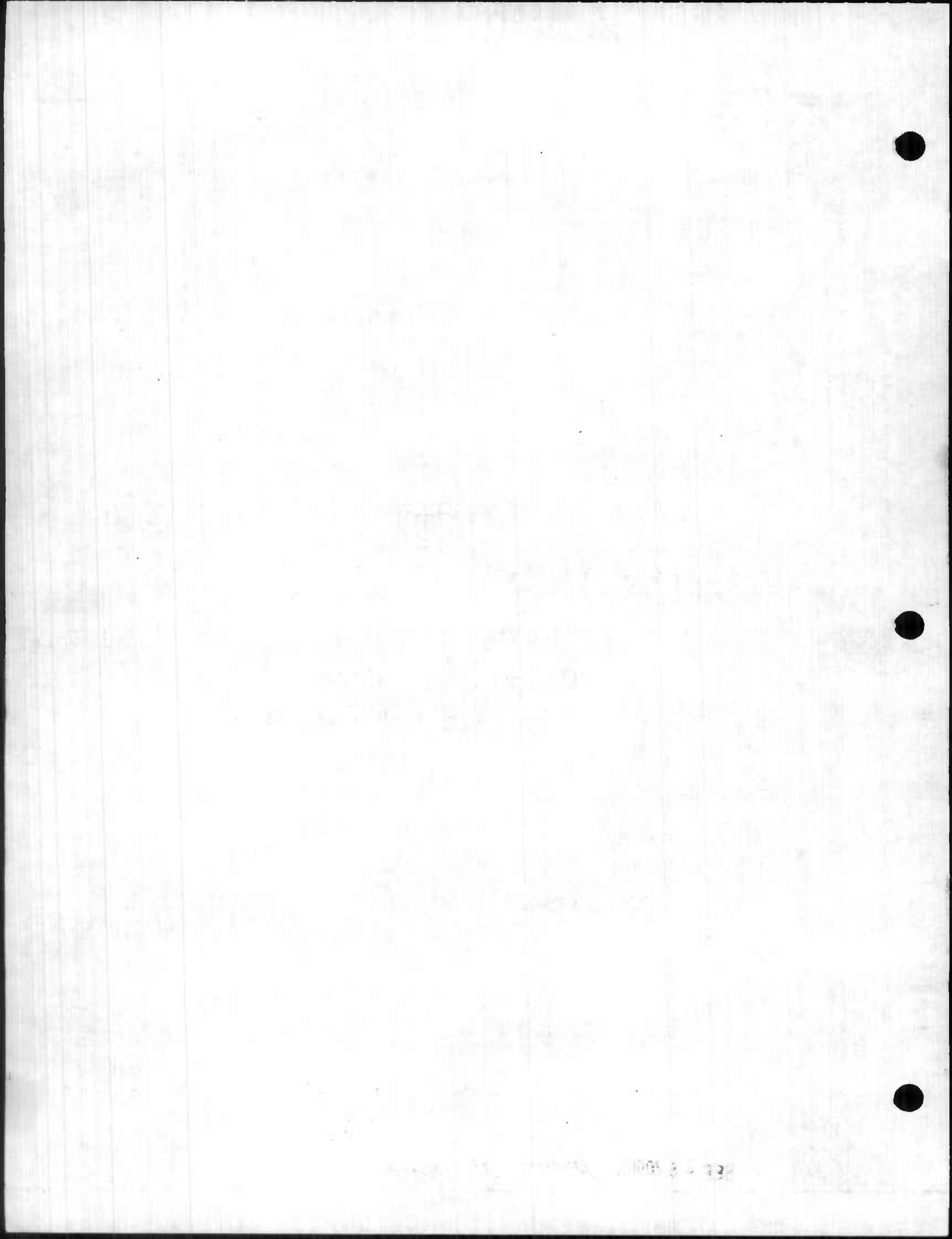
Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

BAYLOR, HERMAN 09/23/00 R 1003



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32214

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) ARIANNA MICHELLE BUTTS						2. Date of Death Month Day Year SEPT. 20, 2000		3. Time of Death 12:35am		
4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER						4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES		
5. Social Security Number NONE		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 20, 2000		9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent										
10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location LANDOVER				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 6812 FLAGSTAFF STREET				10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BI-RACIAL			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) NONE College (1-4 or 5+) NONE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE - INFANT			16b. Kind of Business/Industry NONE - INFANT			
17. Father's Name (First, Middle, Last) MICHAEL CHRISTOPHER BUTTS						18. Mother's Name (First, Middle, Maiden Surname) ZINATA LASHAUN RICKS				
19a. Informant's Name/Relationship (Type, Print) MICHAEL C. BUTTS						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6812 FLAGSTAFF ST. LANDOVER, MD 20785				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery			20c. Location - City or Town, State 9/23/2000 Mill Hall, PA.				
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Extreme Prunahinty										
23b. Immediate Cause (Final disease or condition resulting in death) Nonviable										
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 026819			29d. Date signed (Month, Day, Year) 9/21/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL CHAURY MD - 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785										
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32215

amend item 23a,27,per me G788 10/16/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD Q. BROWNE				2. Date of Death Month Day Year September 26 2000		3. Time of Death 11:30 P.M.	
	4a. Facility Name (If not institution, give street and number) Greater Laurel Beltsville Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 220-92-2987	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 12, 1954		9. Birthplace (State or Foreign Country) Liberia, W.A.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Lanham		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 9101 Sheridan Court				10f. Zip Code 20706		10g. Citizen of What Country? Liberia, West Africa		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur		16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Austin H. Browne Sr.				18. Mother's Name (First, Middle, Maiden Surname) Rebecca A. Powell				
19a. Informant's Name/Relationship (Type, Print) Rebecca Bryant Browne/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9101 Sheridan Court, Lanham, Maryland 20706				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Ceme.		Date 10/07 2000		20c. Location - City or Town, State Adelphi, Maryland		
21. Signature of Funeral Service Licensee Nancy A. Pecanier				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTROPHIC CARDIOMYOPATHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier [Signature]				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 27, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Handwritten signature or initials.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32216

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FREDA JOSEPHINE BODEN				2. Date of Death Month Day Year SEPT. 25, 2000		3. Time of Death 2:05 PM	
	4a. Facility Name (If not institution, give street and number) 4127 TURKEYFOOT RD.				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 215-14-2448		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) 6/13/1919	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County CARROLL		10c. City, Town or Location WESTMINSTER	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4127 TURKEYFOOT RD.		10f. Zip Code 21158		10g. Citizen of What Country? USA.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIETARY DEPARTMENT		16b. Kind of Business/Industry HOSPITAL				
17. Father's Name (First, Middle, Last) JAMES REESE				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE SWOPE				
19a. Informant's Name/Relationship (Type, Print) LAWRENCE E. BODEN-HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4127 TURKEYFOOT RD., WESTMINSTER, MD. 21158				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EVERGREEN MEM. GARDENS		20c. Location - City or Town, State 9/28/00 FINKSBURG, MD.				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial infarction Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Diabetes mellitus								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number D 23 443		29d. Date signed (Month, Day, Year) 09/28/00				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NAYAN VAYWALA MD 1130 Baltimore Blvd Westminister MD 21157								
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32217

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Betty Lou Brosenne				2. Date of Death Month Day Year Sept. 23, 2000				3. Time of Death 4:46am	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-54-2936		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Dec 19, 1936		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD		10b. County Howard		10c. City, Town or Location Marriottsville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 11376 Barley Field Way				10f. Zip Code 21104	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store Owner				16b. Kind of Business/Industry Convenience Store				17. Father's Name (First, Middle, Last) David Lee Green	
	18. Mother's Name (First, Middle, Maiden Surname) Betty Lee Schrader				19a. Informant's Name/Relationship (Type, Print) Mrs. Cindy Lee Floyd (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11376 Barley Field Way, Marriottsville, MD 21104	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery				20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee Brian L. Hays				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lung cancer - bronchioalveolar Due to (or as a consequence of): lung cancer small cell Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) hospice				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier Judy Williams				29c. License number D39099				29d. Date signed (Month, Day, Year) 9-23-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jedrey Williams MD, GBMC, Baltimore, MD				31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature Benita B. Sparks		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32218

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRTLE KAEFER BEBEE			2. Date of Death Month Day Year September 25, 2000		3. Time of Death 6:15 AM	
	4a. Facility Name (If not institution, give street and number) 107 Oakdale Road			4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 105-10-3568	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 17, 1915	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 107 Oakdale Road		10f. Zip Code 21801		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Elementary school		
	17. Father's Name (First, Middle, Last) Christian Kaefer			18. Mother's Name (First, Middle, Maiden Surname) Ella Nieman			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Rev. Arthur F. Bebee/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Oakdale Rd., Salisbury, MD 21801			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Duell Cemetery		Date 10/4/00	20c. Location - City or Town, State Orchard Park, NY	
	21. Signature of Funeral Service Licensee MO1051 David A. Simpson		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Intracranial hemorrhage with aneurysm - primary site undetermined 3 1/2 mos. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier James H. Clifford MD				29c. License number 0001969		29d. Date signed (Month, Day, Year) 9/26/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES H. CLIFFORD MD 106 PINE BLUFF Rd Suite 12 Salisbury, MD 21801							
31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature B. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32219

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES Blackstock

2. Date of Death

Month 10 Day 2 Year 2000

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

HERITAGE HARBOUR HEALTH & REHAB

4b. City, Town, or Location of Death

ANNAPOLIS, MD

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

219-03-1918

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8/4/16

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Tracys Landing

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6271 Solomons Island Road

10f. Zip Code

20779

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1942
1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Project Manager

16b. Kind of Business/Industry

Industrial Construction

17. Father's Name (First, Middle, Last)

John Blackstock

18. Mother's Name (First, Middle, Maiden Surname)

Nannie Powell

19a. Informant's Name/Relationship (Type, Print)

Eleanor Blackstock (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6271 Solomons Island Road, Tracys Landing, MD 20779

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Memorial Gardens

Date

Oct. 6, 2000

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Lee Funeral Home Calvert, P.A.
8125 Southern Maryland Blvd. Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death
Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying PhysicianTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D41978

29d. Date signed (Month, Day, Year)

10-2-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Javakolimis 1 Hosp St Chevy MD 20785

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32220

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUBY LEE CROCKETT				2. Date of Death Month 9 Day 21 Year 00		3. Time of Death 4:11 PM	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 309 42 5633		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 19, 1939	
	9. Birthplace (State or Foreign Country) Indiana		10a. State DC		10b. County Washington D.C.		10c. City, Town or Location Washington D.C.	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1617 T. Street SE		10f. Zip Code 20020		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Manager		16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Reuben Butler	
	18. Mother's Name (First, Middle, Maiden Surname) Odessa Johnson		19a. Informant's Name/Relationship (Type, Print) Sandra Butler /sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10187 Campus Way South Upper Marlboro, MD 20774		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Entombment	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem.		20c. Location - City or Town, State Suitland, Maryland		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC OVARIAN CANCER Due to (or as a consequence of): b. ELECTROLYTE IMBALANCE Due to (or as a consequence of): c. BOWEL OBSTRUCTION Due to (or as a consequence of): d. SEPSIS, PULMONARY CONGESTION		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D55703		29d. Date signed (Month, Day, Year) 9/21/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bernane 3001 Hospital Dr. Cheverly, MD		31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature <i>[Signature]</i>		33. State Registrar	

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32221

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Frederick Clark				2. Date of Death Month Day Year September 19, 2000		3. Time of Death 1630	
	4a. Facility Name (If not Institution, give street and number) 30170 Dudley Road				4b. City, Town, or Location of Death Mechanicsville		4c. County of Death St. Mary's County	
Funeral Director	5. Social Security Number 579-36-3318		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71		8. Date of Birth (Month, Day, Year) Jan. 18, 1929	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Mechanicsville	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 30170 Dudley Road		10f. Zip Code 20659		
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-1953		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Police Officer Law Enforcement		16b. Kind of Business/Industry		
17. Father's Name (First, Middle, Last) Edward F. Clark				18. Mother's Name (First, Middle, Maiden Surname) Mary Agnes Wright				
19a. Informant's Name/Relationship (Type, Print) Shirley M. Clark (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30170 Dudley Road Mechanicsville, MD 20659				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Date September 23, 2000		20d. Location - City or Town, State Clinton, Maryland		
21. Signature of Funeral Service Licensee St. F. Smith				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease Due to (or as a consequence of): b. diabetes mellitus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier R. Timothy Pace				29c. License number D22574		29d. Date signed (Month, Day, Year) September 20, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Timothy Pace, M.D. 12070 Old Line Center, Suite 202, Waldorf, Maryland 20602								
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature B. Sparks				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32222

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Edgar Chandler

2. Date of Death

Month

Day

Year

09-27-00

3. Time of Death

7:15 am.

4a. Facility Name (If not institution, give street and number)

Crescent Cities Center

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

577-28-5755

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 15, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

10b. County

District of Columbia

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3122 Newton St., N.E.

10f. Zip Code

20018

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Callie Chandler

19a. Informant's Name/Relationship (Type, Print)

Johnnie M. Chandler - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3122 Newton St., N.E. Wash., D.C. 20018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Park

Date

10/2/2000

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asphyctic Pneumonia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John T. Stewart III MD

29c. License number

D 45660

29d. Date signed (Month, Day, Year)

9-28-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

14300, GALLANT FLEX LN, 12M, Bowie MD 20715

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

John T. Stewart III

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32223

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HESTER EVALINA CONWAY

2. Date of Death

Month

Day

Year

SEPTEMBER 20 2000

3. Time of Death

11:09 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

072-32-1746

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 9, 1937

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4718 Lakeland Road

10f. Zip Code

20740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Benny Woods

18. Mother's Name (First, Middle, Maiden Surname)

Henrietta Barnett

19a. Informant's Name/Relationship (Type, Print)

Ayanna Garment/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4718 Lakeland Road, College Park, Maryland 20740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Park Maryland National Mem.

Date

09/25 2000

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

Nancy A. B...
Nancy A. B...

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CONGESTIVE HEART FAILURE

Approximate Interval Between Onset and Death

YEARS

Due to (or as a consequence of):

b.

CARDIOMYOPATHY

" "

Due to (or as a consequence of):

c.

ATRIAL FIBRILLATION

" "

Due to (or as a consequence of):

d.

HYPERTENSION

" "

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SMOKING

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samuel W. Alleyne, M.D.

29c. License number

D 25766

29d. Date signed (Month, Day, Year)

9/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samuel W. Alleyne, M.D., 6001 Landover Road, Landover, Maryland 20785

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Sparks

State
Registrar

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32224

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carlton A. Carter		2. Date of Death Month September Day 20 Year 2000		3. Time of Death 8:50 P.M.
	4a. Facility Name (If not institution, give street and number) Civista Medical Center		4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles
Funeral Director	5. Social Security Number 579-46-2564	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Mar. 20, 1937		9. Birthplace (State or Foreign Country) Washington, DC		
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince George		10c. City, Town or Location Upper Marlboro	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 12221 West View Drive			10f. Zip Code 20772		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-1957		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. African American					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Police Officer		16b. Kind of Business/Industry Government
17. Father's Name (First, Middle, Last) Samuel Carter			18. Mother's Name (First, Middle, Maiden Surname) Marie Robinson		
19a. Informant's Name/Relationship (Type, Print) Donald E. Carter (Son)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9881 Goodluck Rd., Lanham, Md. (20706)		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem		Date 9/27/00	20c. Location - City or Town, State Suitland, Md.
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. (Wash., D.C. 20019)		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Liver Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hepatoportal Syndrome Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatoportal Syndrome					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D-0021031		29d. Date signed (Month, Day, Year) 9/21/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Leatherwood, M.D.		12070 Old Line Center, Suite 202 Waldorf, Maryland 20602			
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32225

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Mildred Carpenter				2. Date of Death Month Day Year Sept. 23 2000				3. Time of Death 12:35 P.M.	
	4a. Facility Name (If not institution, give street and number) Glady's Spellman Nursing Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577 01 0867		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) June 17, 1913		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Temple Hills				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3103 Marilyn Drive				10f. Zip Code 20748		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) James Owens				18. Mother's Name (First, Middle, Maiden Surname) Annie Thomas					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frederick E. Carpenter Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 94 Deale Maryland 20751					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 27, 2000 Fort Lincoln Cemetery				20c. Location - City or Town, State Brentwood Maryland			
	21. Signature of Funeral Service Licensee Michael L. Byle				22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie Maryland 20715					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Advanced Dementia Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier N. Javakoli M.D.				29c. License number D41978		29d. Date signed (Month, Day, Year) 9-25-2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Javakoli 1405 PSI charity M.D 20785									
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature B. Sparks								

April 1, 1961

Dear Mr. [illegible]

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32226

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy E. Carroll

2. Date of Death

SEPT

Day

29

Year

2000

3. Time of Death

10:42 PM

4a. Facility Name (If not institution, give street and number)

CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death

LAPLATA

4c. County of Death

CHARLES

Funeral
Director

5. Social Security Number

220-16-1916

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

01-16-1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Nanjemoy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3211 Poseytown Road

10f. Zip Code

20662

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Others Homes

17. Father's Name (First, Middle, Last)

Lemuel Carroll

18. Mother's Name (First, Middle, Maiden Surname)

Lena H. Henson

19a. Informant's Name/Relationship (Type, Print)

Michele Adams/Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1835 East Wolfchase Circle, Cordova, Tennessee 38018

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Church of The Lord

Jesus Christ Cemetery

Date

10-03-

2000

20c. Location - City or Town, State

Ironsides, Maryland

21. Signature of Funeral Service Licensee

M00668

22. Name and Address of Facility

Williams Funeral Home, P.A.

20640

4270 Hawthorne Road, Indian Head, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SQUAMOUS CELL CANCER OF VULVA.

Due to (or as a consequence of):

b. METASTATIC CANCER.

Due to (or as a consequence of):

c. HYPERCALCEMIA OF MALIGNANCY

Due to (or as a consequence of):

d. RIGHT LUNG MASS.

Approximate Interval Between Onset and Death

A yrs.

X WKS.

X WKS.

X WKS.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RIGHT KIDNEY MASS.

GRAVES DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-20629

29d. Date signed (Month, Day, Year)

9/30/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE H. WATHEN MD 11345 PEMBROOKE SQ. SUITE #103 WALDORF, MD. 20603

State
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32227

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Stanley Cox				2. Date of Death Month Day Year September 23 2000				3. Time of Death 10:45 PM	
	4a. Facility Name (If not institution, give street and number) 9355 Woodsboro Rd.				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 076-16-1961		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 23, 1922		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 9355 Woodsboro Rd.				10f. Zip Code 21701	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W W II	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) carpenter				16b. Kind of Business/Industry construction				17. Father's Name (First, Middle, Last) Harry Stanley Cox	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Mildred Perry				19a. Informant's Name/Relationship (Type, Print) Julia C. Hood/ daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9355 Woodsboro Rd. Frederick, MD 21701	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation, Inc.				20c. Location - City or Town, State Hampstead, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i>				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Malignant Lymphoma</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>	
	29c. License number b1462c				29d. Date signed (Month, Day, Year) Sept 25, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Thomas S. Sparks</i>	
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000				32. Registrar's Signature <i>[Signature]</i>				33. Date of Death (Month, Day, Year) 21701	

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32228

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Blanche E. Cox				2. Date of Death Month Day Year Sept 26, 2000				3. Time of Death 8:06 am	
	4a. Facility Name (If not institution, give street and number) Charlestown Care Center				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-38-2374		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1904		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10c. City, Town or Location Catonsville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10e. Street and Number 713 Maiden Choice Lane				10f. Zip Code 21228	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry Public School				17. Father's Name (First, Middle, Last) David Cox	
	18. Mother's Name (First, Middle, Maiden Surname) Eva Osborne				19a. Informant's Name/Relationship (Type, Print) Virginia Giles / cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 Williams Dr., Havre de Grace, MD 21078	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Belair Memorial Garden				20c. Location - City or Town, State Belair, Maryland	
	21. Signature of Funeral Service Licensee Lisa Scott				22. Name and Address of Facility Lisa M. Scott Funeral Services 552 Lewis Street, Havre de Grace, MD 21078				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier Andres Salazar MD				29c. License number D 51057				29d. Date signed (Month, Day, Year) September 26, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228				31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature G. Sparks		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32229

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kaylee May Creese				2. Date of Death Month Day Year SEPTEMBER 27 2000				3. Time of Death 9:58 A.M.	
	4a. Facility Name (If not Institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number None	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 30min September 27, 2000		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent		10a. State Maryland		10b. County Cecil		10c. City, Town or Location Elkton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 20 Oak Tree Lane				10f. Zip Code 21921		10g. Citizen of What Country? United States				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None			16b. Kind of Business/Industry None			
17. Father's Name (First, Middle, Last) Troy Creese				18. Mother's Name (First, Middle, Maiden Surname) Shelly Bosley						
19a. Informant's Name/Relationship (Type, Print) Troy and Shelly Creese / parents				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Oak Tree Lane, Elkton, Maryland 21921						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) All Saints Cemetery		Date September 30, 2000		20c. Location - City or Town, State Newark, Delaware		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. PRE TERM DELIVERY Due to (or as a consequence of):						
				b. INCOMPETENT CERVIX Due to (or as a consequence of):						
				c. Due to (or as a consequence of):						
				d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier 				29c. License number D18554		29d. Date signed (Month, Day, Year) 9/28/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTO RIVERA MD 1232 Laurel Rd S. 301, BALTO. MD 21237										
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32230

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUTH VIRGINIA CHATHAM		2. Date of Death Month Day Year September 28 2000		3. Time of Death 1608
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 218-05-8967	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) JULY 6, 1916		9. Birthplace (State or Foreign Country) MARYLAND		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State MARYLAND	10b. County WICOMICO	10c. City, Town or Location SALISBURY		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 5183 SHARPS POINT RD		10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER		16b. Kind of Business/Industry GARMENT COMPANY		
	17. Father's Name (First, Middle, Last) JOHN A. PARKER		18. Mother's Name (First, Middle, Maiden Surname) MILLIE BETTS		
	19a. Informant's Name/Relationship (Type, Print) GARY CHATHAM - NEPHEW		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28079 RIVERSIDE DR. EXT. SALISBURY, MD 21801		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SHAD POINT CEMETERY		20c. Location - City or Town, State 10/2/00 SHAD POINT, MARYLAND
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <u>CARDIO PULMONARY ARREST</u> Due to (or as a consequence of): b. <u>ACUTE MYOCARDIAL INFARCTION</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D54807		29d. Date signed (Month, Day, Year) 09-28-00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMESH AGARWAL, M.O. PRMC SALISBURY, MD 21801				
State Registrar	31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature <i>[Signature]</i>		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32231

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JENNINGS MARSHALL CRIDER				2. Date of Death Month Day Year Sept. 27 2000				3. Time of Death 9:25 a.m.	
	4a. Facility Name (If not institution, give street and number) 8208 E Street				4b. City, Town, or Location of Death Chesapeake Beach				4c. County of Death Calvert	
Funeral Director	5. Social Security Number 225 30 4890		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) July 22, 1929		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Calvert		10c. City, Town or Location Chesapeake Beach				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 8208 E Street				10f. Zip Code 20732		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) engineer			16b. Kind of Business/Industry county government		
	17. Father's Name (First, Middle, Last) John Henry Crider				18. Mother's Name (First, Middle, Maiden Surname) Hazel Fleta Ritchie					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Mrs. Marilyn E. Crider / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8208 E. St., Box 31, Chesapeake Beach, MD 20736					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 9-28-00		20c. Location - City or Town, State Alexandria, VA	
	21. Signature of Funeral Service Licensee Charles F. Bell				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) e. Adenocarcinoma of lungs Due to (or as a consequence of): b. Squamous cell carcinoma of larynx Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Resident <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No 28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier J. M. Brooks										
29c. License number 059926										
29d. Date signed (Month, Day, Year) 9-28-00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Michael Brooks, M.D. Prince Frederick, MD										
31. Date filed (Month, Day, Year) SEP 28 2000										
32. Registrar's Signature Benita S. Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

SEP 2 1964

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32232

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ralph D. Davis				2. Date of Death Month Day Year SEPT. 21, 2000				3. Time of Death 1846 PM					
	4a. Facility Name (If not institution, give street and number) MALCOLM GROW HOSPITAL				4b. City, Town, or Location of Death A.A.F.B.				4c. County of Death PRINCE GEORGES					
Funeral Director	5. Social Security Number 321 20 4875		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F XX		7. Age (In yrs. last birthday) 71 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) April 19, 1929		9. Birthplace (State or Foreign Country) Clinton, IL	
	Usual Residence of Decedent													
10a. State MD		10b. County P.G.		10c. City, Town or Location Upper Marlboro						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 9115 Marlboro Pike Lot 62						10f. Zip Code 20772				10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)						16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Boatsman's Male Second Class				16b. Kind of Business/Industry U.S. Navy				
17. Father's Name (First, Middle, Last) Ralph Wick Davis						18. Mother's Name (First, Middle, Maiden Surname) Nellie May Gandy								
19a. Informant's Name/Relationship (Type, Print) Dorothy Davis (WIFE)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9115 Marlboro Pike Lot 62, Upper Marlboro, MD 20772								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery			20c. Location - City or Town, State Cheltenham, Maryland					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735								
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier 						29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPT. 22, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Calton Wake, MD 111 Penn Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year) SEP 26 2000						32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32233

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ZENOBIIE DAVIS JR.				2. Date of Death Month Day Year Sept. 25, 2000		3. Time of Death 6:18 p.m.	
	4a. Facility Name (If not institution, give street and number) FutureCare-Pineview				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 578-70-9528	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 20, 1951		9. Birthplace (State or Foreign Country) Nash County, NC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Prince Georges		10c. City, Town or Location Clinton			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 9106 Pineview Lane			10f. Zip Code 20735		10g. Citizen of What Country? U. S. A.		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) I College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unavailable			16b. Kind of Business/Industry Unavailable		
	17. Father's Name (First, Middle, Last) Zenobie Davis, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Bertha Fobbs			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Bertha Davis (Mother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Brinkley Station Dr. Temple Hills, Md. 20748				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hills Memorial Gardens		Data Oct 2,		20c. Location - City or Town, State Clinton Md.	
	21. Signature of Funeral Service Licensee Wanda C. Bacon CCO 361			22. Name and Address of Facility Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D.C. 20010				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Due to (or as a consequence of): MI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Anoxia Due to (or as a consequence of): Passive Emboli / Atherosclerosis							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hx. Anoxic Encephalopathy ht Hemiparesis Aphasia							
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier B. Pishdad				29c. License number D-51520		29d. Date signed (Month, Day, Year) 9-27-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave., S.E. Suite 202 Wash., D.C. 20019								
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature [Signature]				

ORIGINAL

Cardiac Arrhythmia
MI

Arrhythmia
Pacemaker / Atrial

Heart Arrhythmia
in them
Atrial

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32234

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John B. Denit				2. Date of Death Month Day Year September 28, 2000				3. Time of Death 9:35 AM		
	4a. Facility Name (If not institution, give street and number) Braford Oaks Nursing & Rehab Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 579-16-3059		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) February 24, 1916		9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location District Heights		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2515 Edfeldt Drive				10f. Zip Code 20747		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? WWII & 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mailer				16b. Kind of Business/Industry Washington Post		
	17. Father's Name (First, Middle, Last) John H. Denit				18. Mother's Name (First, Middle, Maiden Sumama) Marie A. Mack						
	19a. Informant's Name/Relationship (Type, Print) Phyllis A. Denit/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery 10/4/00 Cheltenham, MD				20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic lung cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <i>One wk.</i>						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Sam Tellawi</i>				29c. License number D34274		29d. Date signed (Month, Day, Year) 9.28.2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sam Tellawi, M.D. 7700 Old Branch Ave., Clinton, MD 20735											
31. Date filed (Month, Day, Year) SEP 29 2000				32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

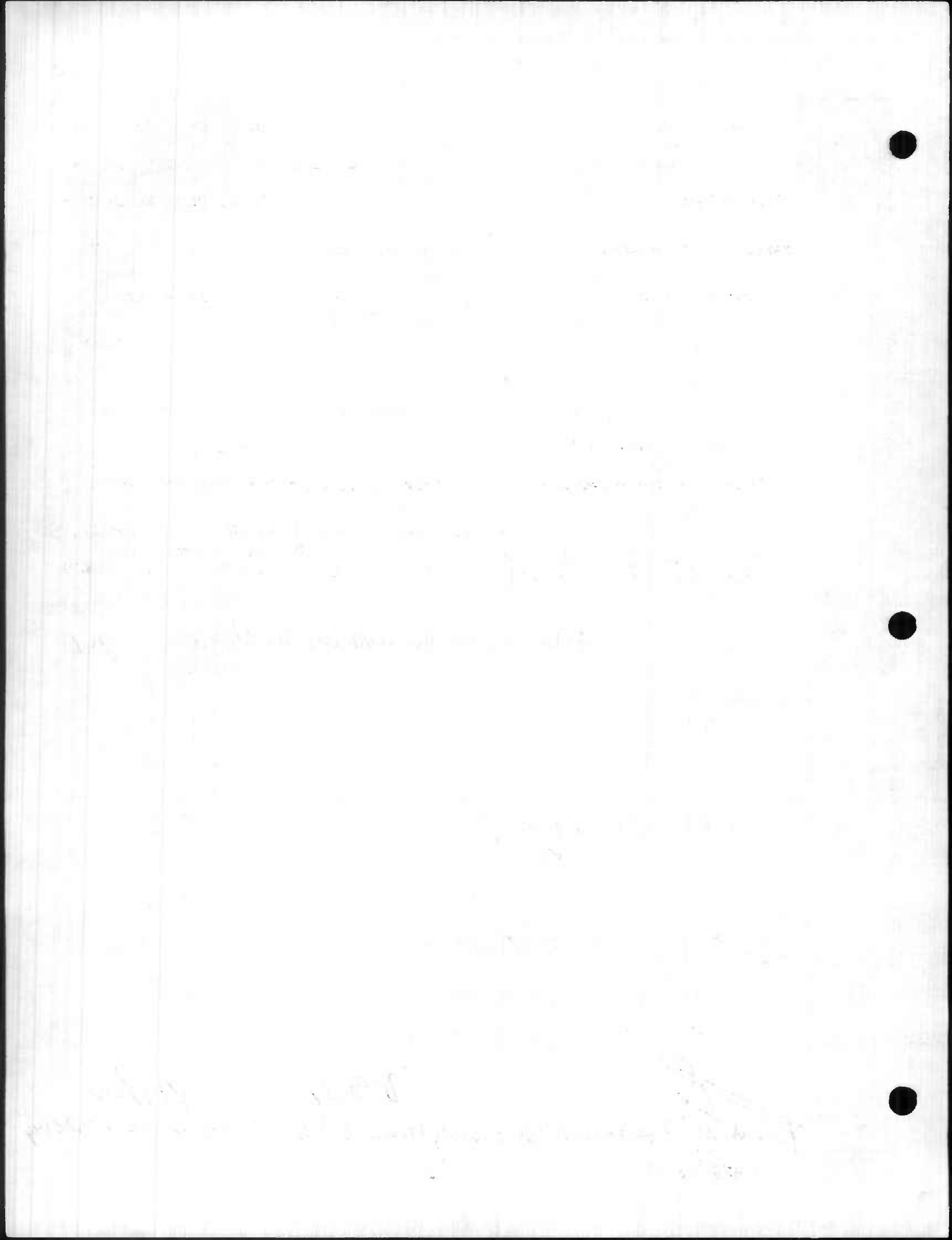
State of Maryland / Department of Health and Mental Hygiene 00 32235
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lureva Durant				2. Date of Death Month: Sept. Day: 24 Year: 2000		3. Time of Death 6:21PM	
	4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital				4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 143-30-7644		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 8, 1924	
	9. Birthplace (State or Foreign Country) North Carolina		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: Prince George's 10c. City, Town or Location: Upper Marlboro 10d. Inside City Limits: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: Black		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 5+ Collage (1-4 or 5+): 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher	
	16b. Kind of Business/Industry Government		17. Father's Name (First, Middle, Last) William Henry McDuffie		18. Mother's Name (First, Middle, Maiden Surname) Ida Smith		19a. Intendant's Name/Relationship (Type, Print) Rozelyn Durant - Daughter	
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 Colton St., Upper Marlboro, MD 20774		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rockfish Memorial Cem. 9/29/2000 Fayetteville, NC		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alzheimer's Disease		Approximate Interval Between Onset and Death yr	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer's Disease				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 		29c. License number D19431		29d. Date signed (Month, Day, Year) 9/25/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frank M. Ryan 11701 Livingston Rd #205, Ft. Washington MD 20744							
State Registrar	31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32236

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER ALOYSIUS DIXON				2. Date of Death Month Day Year September 27, 2000		3. Time of Death 3:30 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 578-05-2288		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 96 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 19, 1904	9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ST. MARY'S		10c. City, Town or Location DRAYDEN			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 45810 BOOTH ROAD				10f. Zip Code 20630		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Processor			16b. Kind of Business/Industry Food	
17. Father's Name (First, Middle, Last) Walter Edward Dixon				18. Mother's Name (First, Middle, Maiden Surname) Alice Virginia Grimes				
19a. Informant's Name/Relationship (Type, Print) LLOYD G. DIXON - BROTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45810 BOOTH ROAD, DRAYDEN, MARYLAND 20630				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY, OCT. 2, 2000, SUITLAND, MARYLAND		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee MARK G. BROHAWN MO0053				22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardiopulmonary Failure Due to (or as a consequence of): b. Cardiomyopathy Due to (or as a consequence of): c. Coronary Artery Disease Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 wks 4 wks 1 yr								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner				29b. Signature and title of certifier James P. Jarboe MD				
				29c. License number D 06419		29d. Date signed (Month, Day, Year) 9-28-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES P. JARBOE, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636								
31. Date filed (Month, Day, Year) OCT 02 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or date, located in the center of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32237

Amend Item 18, 10/2/00,

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last)

Rosalie Maddelena Downer

2. Date of Death

September 29, 2000

3. Time of Death

10:35 am

4a. Facility Name (If not institution, give street and number)

Brightview Assisted Living

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

218-54-1387

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

8. Date of Birth

March 17, 1915

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

659 Alliance Street

10f. Zip Code

21078

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
Twelve Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Personal Residence

17. Father's Name (First, Middle, Last)

Carlo Buscemi

18. Mother's Name (First, Middle, Maiden Surname)

Antonina Zammuto
~~Antonina Sumuto~~

19a. Informant's Name/Relationship (Type, Print)

Robert C. Downer (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1511 SUPERIOR STREET, HAVRE DE GRACE, MD. 21078

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harford Memorial Gardens 10/2/00 Aberdeen, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766

23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hidden Aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

c. congestive heart failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hispup sim 219 S. Union Ave Hdb MD 21078

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

Shirley B. Sparks

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32238

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GARY ERMER

2. Date of Death

Month

Day

Year

9

26

2000

3. Time of Death

0920

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

213-66-3985

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

05/31/1956

9. Birthplace (State or Foreign Country)

WASH. D.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

ANNE ARUNDEL

10c. City, Town or Location

CROWNSVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

395 ELM TRAIL

10f. Zip Code

21032

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HEAVY EQUIPMENT OPERATOR CONSTRUCTION

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

ROBERT ERMER

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

REBECCA ERMER/ SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

395 ELM TRAIL CROWNSVILLE, MD. 21032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. VETERANS CEMETERY

Date

10/2/2000

20c. Location - City or Town, State

CROWNSVILLE

21. Signature of Funeral Service Licensee

KYLE SIMONS M01206

22. Name and Address of Facility

BEALL FUNERAL HOME

6512 N.W. CRAIN HWY. BOWIE, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatic Failure

Due to (or as a consequence of):

b. Cirrhosis

Due to (or as a consequence of):

c. Hepatitis C

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcoholism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Anthony J. Calabrese MD

29c. License number

DZ5060

29d. Date signed (Month, Day, Year)

9/26/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANTHONY J. CALABRESE, MD 171 DEFENSE HWY ANNAP. MD 21401

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32239

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lena Ebron</i>				2. Date of Death Month <i>Sept</i> Day <i>27</i> Year <i>2000</i>		3. Time of Death <i>4:30AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Ft. Washington Medical Center</i>				4b. City, Town, or Location of Death <i>Ft. Washington</i>		4c. County of Death <i>Prince Georges'</i>	
Funeral Director	5. Social Security Number <i>240-03-8403</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>84</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Dec 6, 1915</i>	
	9. Birthplace (State or Foreign Country) <i>North Carolina</i>		10a. State <i>MD</i>		10b. County <i>Prince Georges'</i>		10c. City, Town or Location <i>Ft. Washington</i>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>3815 Copperville Way</i>		10f. Zip Code <i>20744</i>		
10g. Citizen of What Country? <i>U.S.A.</i>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>		16b. Kind of Business/Industry <i>Private</i>		
17. Father's Name (First, Middle, Last) <i>David Ebron</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Lucy Griffin</i>				
19a. Informant's Name/Relationship (Type, Print) <i>William H. Ebron-Son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3815 Copperville Way Ft. Washington MD 20744</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Homestead Memorial Garden</i>		20c. Location - City or Town, State <i>10-1-00 Greenville, NC</i>		20d. Date		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>J.B. Jenkins Funeral Home 7474 Landover Rd Landover MD 20785</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Pneumonia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dehydration, Hyperglycemia</i> <i>S/P Cerebrovascular Accident</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>326352</i>		29d. Date signed (Month, Day, Year) <i>Sept 27 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>O Hays 9131 Kistaway Rd Clinton Md-</i>								
31. Date filed (Month, Day, Year) <i>SEP 29 2000</i>				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32240

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEONIA FRANCES EDMONDS

2. Date of Death

Month Day Year
SEPTEMBER 20, 2000

3. Time of Death

6:51 PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

248-38-5420

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 27, 1928 South Carolina

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6917 Kent Town Drive

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Presser

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Brown

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Ruth Hynes

19a. Informant's Name/Relationship (Type, Print)

Alan Way/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2447 Kent Village Place, Landover, Maryland 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

09/27
2000

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perente

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. TERMINAL ARRYTHMIA
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

~ mts

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency
Multifactorial Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. S. Nayar

29c. License number

D-17874

29d. Date signed (Month, Day, Year)

9-22-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. M. NAYAR, MD, 3717 - 38th Ave COTTAGE CITY, MD 20722

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Sparks

Edmonds, Beonia
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32241

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bernice Darlene Erb

2. Date of Death

Month
Sept.Day
21Year
2000

3. Time of Death

3:25PM

4a. Facility Name (If not institution, give street and number)

Westminster Nursing Center

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral
Director

5. Social Security Number

218-40-7949

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 22, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3968 Littlestown Pike

10f. Zip Code

21158

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Shoe Company

17. Father's Name (First, Middle, Last)

Arthur Selby

18. Mother's Name (First, Middle, Maiden Surname)

Effie Wentz

19a. Informant's Name/Relationship (Type, Print)

Barbara A. Selby Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 West Baltimore St. Taneytown, MD 21787

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Mary's Cemetery

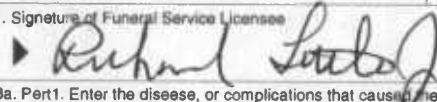
Date

9/26/00

20c. Location - City or Town, State

Silver Run, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Little's F.H. 34 Maple Ave. Littlestown, PA 17340

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Multiple Sclerosis
Due to (or as a consequence of):

b. Pneumonia
Due to (or as a consequence of):

c. _____
Due to (or as a consequence of):

d. _____
Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

13yrs
1wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

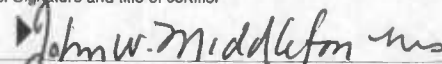
M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D25443

29d. Date signed (Month, Day, Year)

9-21-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John W. Middleton 688 Bole Road, Westminster, Md 21157

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32242

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Frances Ecker						2. Date of Death Month Day Year September 21 2000		3. Time of Death 3:30PM	
	4a. Facility Name (If not institution, give street and number) 22120 Foxlair Rd.						4b. City, Town, or Location of Death Gaithersburg		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-18-1427		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 13, 1920		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1227 Danielle Dr.				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) homemaker			16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Luther Stang						18. Mother's Name (First, Middle, Maiden Surname) Annie Summer				
19a. Informant's Name/Relationship (Type, Print) Marsha Rist/ daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22120 Foxlair Rd. Gaithersburg, MD 20882				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Linganore Cemetery		Date 9/25/00		20c. Location - City or Town, State Unionville, MD		
21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i>						22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Multiple Myeloma 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Heart Disease										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) residence Daughter's						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28e. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Casper E. Cline III</i>				29c. License number D16428		29d. Date signed (Month, Day, Year) 9/23/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Casper E. Cline III 300 W. 9th St. Frederick, MD 21701										
31. Date filed (Month, Day, Year) SEP 25 2000				32. Registrar's Signature <i>Berena B Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32243

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Connie Marie Fugitt				2. Date of Death Month Day Year Sept 22, 2000				3. Time of Death 8:00 AM		
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death P.G.		
Funeral Director	5. Social Security Number 578 14 3887		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) Aug 28, 1910		9. Birthplace (State or Foreign Country) North Carolina		10a. State MD		10b. County P.G.		10c. City, Town or Location Clinton		
Usual Residence of Decedent											
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
10e. Street and Number 9211 Stuart Lane				10f. Zip Code 20735				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Alvaga Jefferson Lee				18. Mother's Name (First, Middle, Maiden Surname) Mattie Eldridge Fuquay							
19a. Informant's Name/Relationship (Type, Print) Becky Lee (NIECE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 A Amberstone Court, Annapolis, MD 21403							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery Sept 28, 2000 Brentwood, Maryland				20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Vince D. Poca				22. Name and Address of Facility Lee Funeral Home 6633 Old Alexandria Ferry Road, Clinton, MD 20735							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Pulmonary Edema Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Atrial Fibrillation Due to (or as a consequence of): d. { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Approximate Interval Between Onset and Death 4 days 10 yr 10 yr											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was cause related to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Attending				29c. License number D-24535		29d. Date signed (Month, Day, Year) 9.24.00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Berwa, M.D. 7700 Old Branch Ave, Suite 101, Clinton, Maryland 20735											
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature B. Sparks							

ORIGINAL

10/17/1913

10/17/1913

10/17/1913

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32244

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAURICE

A

FAIR

2. Date of Death

Month Day Year
9/25/2000

3. Time of Death

0514

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONT

Funeral
Director

5. Social Security Number

577-42-2012

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12/12/32

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

MONT

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1913 EAST WEST HIGHWAY

204

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

AIR FORCE

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

COMMUNICATIONS SPECIALIST

16b. Kind of Business/Industry

STATE DEPARTMENT

17. Father's Name (First, Middle, Last)

OLIVER FAIR

18. Mother's Name (First, Middle, Maiden Surname)

Cecelia Statesman

19e. Informant's Name/Relationship (Type, Print)

CYNTHIA FAIR (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2008 OVERTON DRIVE, FORESTVILLE, MD., 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico Nat.

Data

Oct. 2

20c. Location - City or Town, State

Quantico Va.

21. Signature of Funeral Service Licensee

CC0273

22. Name and Address of Facility

JOHN T. RHINES CO., INC.
3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC BRAIN DAMAGE

Due to (or as a consequence of):

b. CARDIOMYOPATHY

Due to (or as a consequence of):

c. LIVER CIRRHOSIS

Due to (or as a consequence of):

d. HYPOTHYROID

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOLIC ABUSE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D48152

29d. Date signed (Month, Day, Year)

9/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL A SEMEGN, MD 1500 FOREST GLEN RD., SILVER SPRING, MD 20910

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32245

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anastasia Fontanilla				2. Date of Death Month Day Year September 28, 2000				3. Time of Death 6:40AM	
	4e. Facility Name (If not institution, give street and number) Livingston Health Care Center				4b. City, Town, or Location of Death Fort Washington				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-18-8170		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88		8. Date of Birth (Month, Day, Year) Sept. 10, 1912		9. Birthplace (State or Foreign Country) Baltimore, Md.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Oxon Hill				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6439 Livingston Road Apt. 201				10f. Zip Code 20745		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Retail		
	17. Father's Name (First, Middle, Last) Constantine Vlahos					18. Mother's Name (First, Middle, Maiden Surname) Georgia Vlangas				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Georgia Mallari/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 9/30/2000		20c. Location - City or Town, State Brentwood, Md.			
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke. (Multiple Cerebrovascular many years Accident) Acute Cardiopulmonary arrest 9/28/00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Alzheimer's Dementia									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
State Registrar	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide									
28a. Date of Injury (Month, Day Year)										
28b. Time of Injury M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Shantha Murthy</i>				29c. License number D24064			29d. Date signed (Month, Day, Year) 9/28/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shantha Murthy, M.D. 6196 Oxon Hill Rd. Oxon Hill, Md. 20745										
31. Date filed (Month, Day, Year) SEP 28 2000					32. Registrar's Signature <i>James D. Sparks</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32246

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALICE KIRSTEN FUESE			2. Date of Death Month Day Year SEPTEMBER 29, 2000		3. Time of Death 10:15 PM	
	4a. Facility Name (If not institution, give street and number) CHARLES COUNTY NURSING & REHAB. CENTER			4b. City, Town, or Location of Death LaPLATA		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 577-28-3561		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 6, 1909
	9. Birthplace (State or Foreign Country) VIRGINIA						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location WALDORF		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 11907 MONTGOMERY LANE			10f. Zip Code 20602		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) GEORGE L. LARSEN			18. Mother's Name (First, Middle, Maiden Surname) STELLA C. WILLIAMS			
	19a. Informant's Name/Relationship (Type, Print) JOSEPH F. FUESE/HUSBAND			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11907 MONTGOMERY LANE, WALDORF, MARYLAND 20602			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEMORIAL GARDENS		Date 10-03-2000		20c. Location - City or Town, State WALDORF, MARYLAND
	21. Signature of Funeral Service Licensee MARK G. BROHAWN		22. Name and Address of Facility THE HUNT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CONGESTIVE HEART FAILURE Due to (or as a consequence of): DILATED CARDIOMYOPATHY Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROVASCULAR ACCIDENT						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
State Registrar	29b. Signature and Title of certifier MD		29c. License number D53885		29d. Date signed (Month, Day, Year) SEPTEMBER 30, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENKAT S. RAMANAN, MD, 6 POST OFFICE ROAD, WALDORF, MARYLAND 20602						
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32247

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DANIEL ANTHONY FERRIS				2. Date of Death Month: SEPT Day: 29 Year: 2000		3. Time of Death 10:09 PM	
	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER				4b. City, Town, or Location of Death LAPLATA		4c. County of Death CHARLES	
Funeral Director	5. Social Security Number 219-56-1030		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 14, 1950	
	9. Birthplace (State or Foreign Country) VIRGINIA		10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location MARBURY	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4305 PIPER LANE		10f. Zip Code 20658		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: USAF 1969-73		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECHNICAL MECHANIC		16b. Kind of Business/Industry KING EL'S AMUSEMENT				
17. Father's Name (First, Middle, Last) WILLIAM JOSEPH FERRIS				18. Mother's Name (First, Middle, Maiden Surname) SHIRLEY CORD				
19a. Informant's Name/Relationship (Type, Print) SHARON FERRIS-SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS #10				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) TRINITY MEM. GARDENS		Date 10-5-00		20c. Location - City or Town, State WALDORF, MARYLAND		
21. Signature of Funeral Service Licensee M00479 <i>Michael D. B...</i>		22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Yahia M. Tagouri MD</i>				29c. License number D-50883		29d. Date signed (Month, Day, Year) 9-30-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YAHIA TAGOURI MD ST. MARYS HOSPITAL DEPT. OF PATHOLOGY 25500 PT. LOOKOUT RD. LEONARDTOWN, MD 20650								
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature <i>B. Sparks</i>						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32248

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>James Fogarty</u>		2. Date of Death Month <u>September</u> Day <u>25</u> Year <u>2000</u>		3. Time of Death <u>11:35 PM</u>
	4a. Facility Name (If not institution, give street and number) <u>The Johns Hopkins Hospital</u>		4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>215-22-1146</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>73</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>6/25/1927</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		
Usual Residence of Decedent					
10a. State <u>MD.</u>		10b. County <u>CARROLL</u>		10c. City, Town or Location <u>FINKSBURG</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <u>2405 SHAWNEE DR.</u>			10f. Zip Code <u>21048</u>		10g. Citizen of What Country? <u>USA.</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WW II</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>5 + 1</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>ACCOUNTANT</u>		16b. Kind of Business/Industry <u>BOWLING CENTERS</u>
17. Father's Name (First, Middle, Last) <u>JAMES JOSEPH FOGARTY JR.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>MARY O. BRENNAN</u>		
19a. Informant's Name/Relationship (Type, Print) <u>MARY A. FOGARTY - WIFE</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2405 SHAWNEE DR., FINKSBURG, MD. 21048</u>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>EVERGREEN MEM. GARDENS</u>		20c. Location - City or Town, State <u>FINKSBURG, MD.</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>FLETCHER FUNERAL HOME</u> <u>254 E. MAIN ST., WESTMINSTER, MD. 21157</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Aspiration pneumonia</u> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <u>20 days</u>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <u>lack of normal airway protective reflexes</u> Due to (or as a consequence of):			<u>1 month</u>
		c. <u>cerebrovascular accident</u> Due to (or as a consequence of):			<u>3 months</u>
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>poor nutritional status</u> <u>depression</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Josh Lanning MD, PhD Intern</u>		29c. License number <u>RES-000</u>		29d. Date signed (Month, Day, Year) <u>September 26, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Josh Lanning MD PhD Johns Hopkins Hospital 600 N. WOLFE ST. BALTIMORE, MD 21205</u>					
31. Date filed (Month, Day, Year) <u>SEP 28 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32249

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELSIE HILL FISHER

2. Date of Death

Month Day Year
SEPTEMBER 23, 2000

3. Time of Death

2:40 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

213-24-8472

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

99

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 6, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1599 East St., #18

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John W. Hill

18. Mother's Name (First, Middle, Maiden Surname)

Lottie Richardson

19a. Informant's Name/Relationship (Type, Print)

Elsie V. Fisher/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1599 East St., #18 Frederick, MD 21701

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Keys Chapel Cemetery

Date

9/26/00

20c. Location - City or Town, State

Oldfields, MD

21. Signature of Funeral Service Licensee

Catharine D. Hartzler

22. Name and Address of Facility

Hartzler Funeral Home
11802 Liberty Rd. Libertytown, MD 2176223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Congestive Heart Failure
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

3 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

28d. Describe how injury occurred

☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mary P. Howell MD

29c. License number

046075

29d. Date signed (Month, Day, Year)

9/24/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary P. Howell 170 Thomas Johnson Dr. Frederick, MD 21701

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Geneva S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


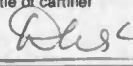
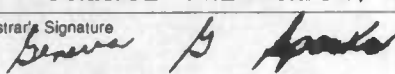
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32250

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD RUDOLPH FAIRCLOTH		2. Date of Death Month Day Year October 2, 2000		3. Time of Death 1740						
	4a. Facility Name (If not institution, give street and number) Calvert Memorial hospital		4b. City, Town, or Location of Death Pr. Frederick		4c. County of Death Calvert						
Funeral Director	5. Social Security Number 244-36-6661	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) May 30, 1929		9. Birthplace (State or Foreign Country) NC								
Usual Residence of Decedent											
10a. State MD		10b. County Calvert		10c. City, Town or Location Huntingtown							
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 621 Walton Road		10f. Zip Code 20639							
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:							
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)							
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Hospital									
17. Father's Name (First, Middle, Last) Arthur Faircloth			18. Mother's Name (First, Middle, Maiden Surname) Beulah Van Hoy								
19a. Informant's Name/Relationship (Type, Print) Mary Faircloth/Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same As #10								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State 10/6/00 Brentwood, MD							
21. Signature of Funeral Service licensee 		22. Name and Address of Facility Raymond-Wood F.H., P.A. P.O. Box 430, Dunkirk, MD 20754									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Respiratory failure Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Pneumothorax Due to (or as a consequence of):</td> </tr> <tr> <td>c. Metastatic lung cancer Due to (or as a consequence of):</td> </tr> <tr> <td>d. CAD</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory failure Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. Pneumothorax Due to (or as a consequence of):	c. Metastatic lung cancer Due to (or as a consequence of):	d. CAD
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory failure Due to (or as a consequence of):	Approximate Interval Between Onset and Death									
	b. Pneumothorax Due to (or as a consequence of):										
	c. Metastatic lung cancer Due to (or as a consequence of):										
	d. CAD										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
A - Fib Sepsis											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 		29c. License number D 50290		29d. Date signed (Month, Day, Year) 10-3-00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DHIREN SHAH, M.D. PRINCE FREDERICK, MD 20678											
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

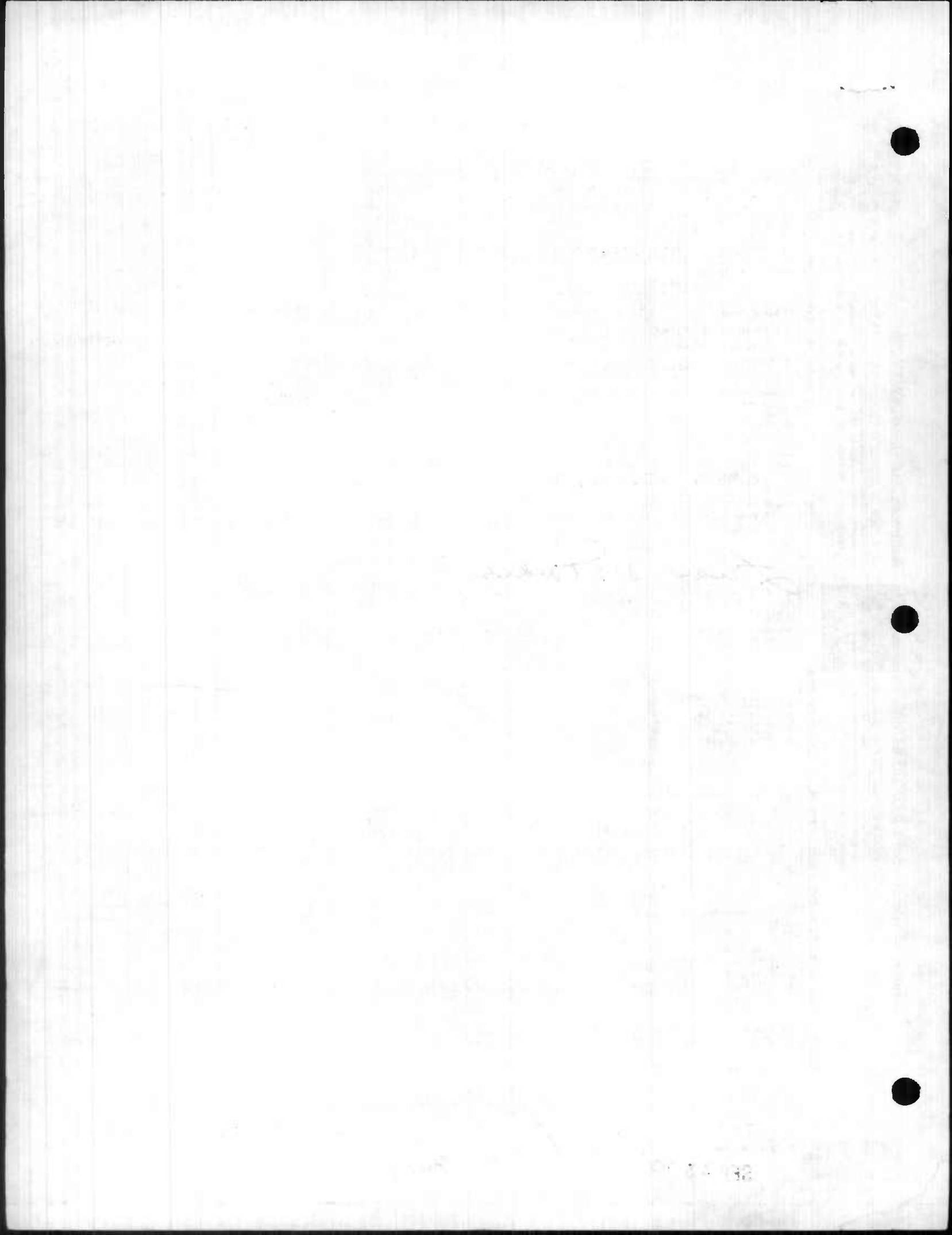
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32251

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED M. GULLEDGE				2. Date of Death Month Day Year SEPT. 19, 2000		3. Time of Death 12:00 PM		
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 239-40-2711		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) MARCH 17, 1931		
	9. Birthplace (State or Foreign Country) NORTH CAROLINA		10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location CAPITOL HEIGHTS		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 420 CEDARLEAF AVE.				
	10f. Zip Code 20743				10g. Citizen of What Country? UNITED STATES				
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR BETHESDA NAVAL FOOD SERVICE		16b. Kind of Business/Industry GOVERNMENT				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) GEORGE SETTLE				18. Mother's Name (First, Middle, Maiden Surname) THEDORE SETTLE				
	19a. Informant's Name/Relationship (Type, Print) CHARLENE WILLIAMS / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 420 CEDARLEAF AVE., CAPITOL HEIGHTS, MD 20743				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Date 09-25-2000		20d. Location - City or Town, State SUITLAND, MARYLAND		
	21. Signature of Funeral Service Licensee <i>Edward M. Dudley</i>		22. Name and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE ACUTE STROKE HYPERTENSION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE, PNEUMONIA, SEPSIS, RENAL INSUFFICIENCY, CONDUCTION SYSTEM DISEASE WITH PERMANENT PACEMAKER, ANEMIA							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier <i>Herman C. Gist, M.D.</i>	
	29c. License number D42982		29d. Date signed (Month, Day, Year) SEPTEMBER 19, 2000						
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HERMAN GIST, M.D., 1160 VARNUM STREET N.E., WASHINGTON, D.C. 20017							31. Date filed (Month, Day, Year) SEP 26 2000	
	32. Registrar's Signature <i>B. Spinks</i>							33. Date of filing (Month, Day, Year) SEP 26 2000	



Bodie Goode Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32252

amend item 23a,27,28a,b,c,d,f,e per me G788 10/30/00 y Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bodie Goode, Jr.				2. Date of Death Month Day Year September 30, 2000				3. Time of Death 1405 pm		
	4a. Facility Name (If not institution, give street and number) 6608 Valley Park Road				4b. City, Town, or Location of Death Seat Pleasant				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 579-06-4365		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 31 Yrs.		8. Date of Birth (Month, Day, Year) 11-18-68		9. Birthplace (State or Foreign Country) Roanoke, VA		
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George		10c. City, Town or Location Capitol Heights		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6608 Valley Park Road				10f. Zip Code 20743		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Building Engineer				16b. Kind of Business/Industry DC Government			
17. Father's Name (First, Middle, Last) Bodie Goode, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Hardy							
19a. Informant's Name/Relationship (Type, Print) Lachele Bethea (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Cypress Creek Drive, Apt. 203 Hyattsville, MD 20782							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Pk. 10/6/00 Landover, MD.				20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pope Funeral Homes, 5538 Marlboro Pk. Forestville, MD. 20747							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONTACT GUNSHOT WOUND OF HEAD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 9/30/00		28b. Time of Injury 2:00 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot self	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence				28f. Location (Street and Number or Rural Route Number, City or Town, State) 6608 Valley Park Rd., Seat Pleasant, Md.			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 01, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) OCT 04 2000				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

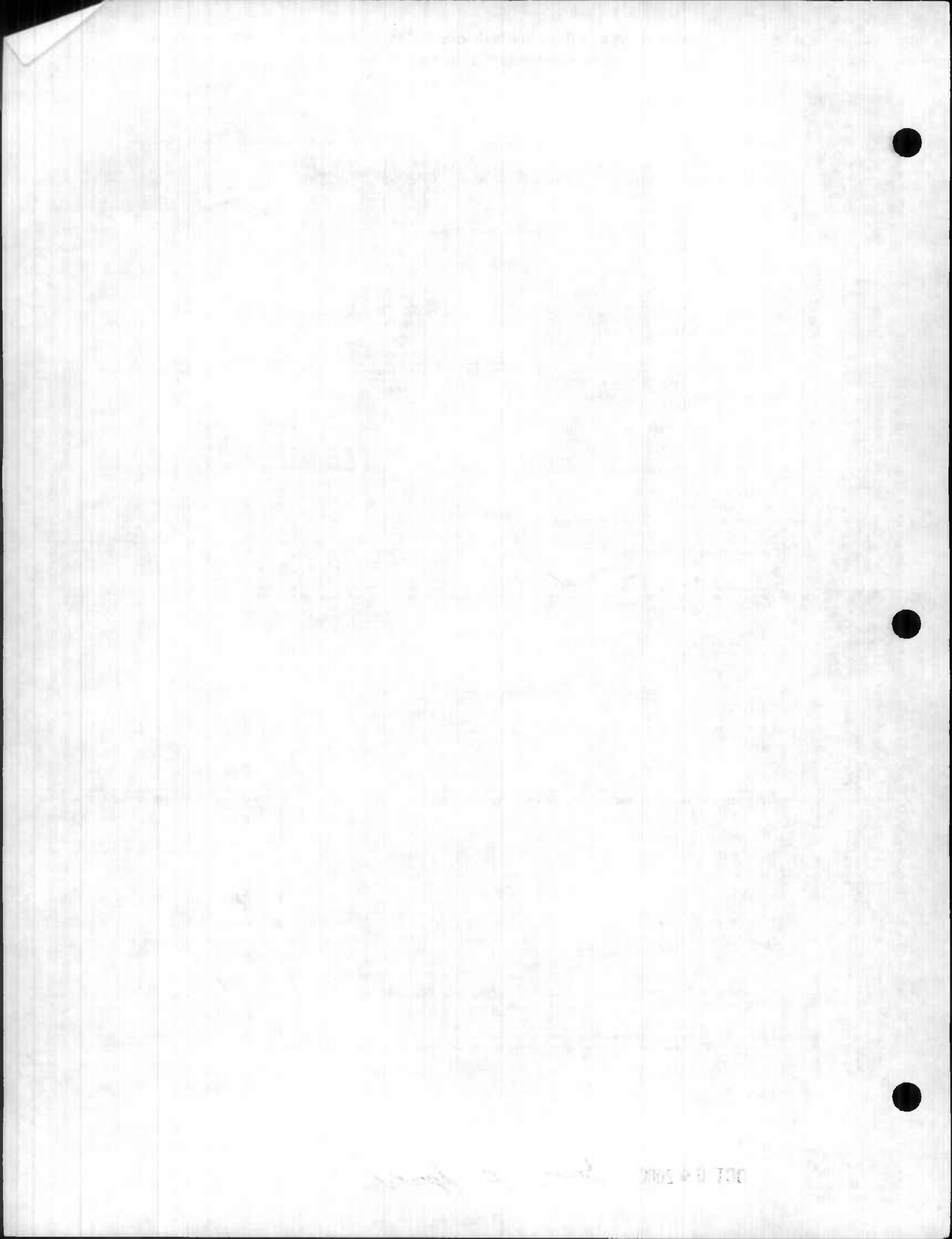
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



1000 4 3 730

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32253

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gary Duane Gibson

2. Date of Death
Month Day Year
SEPTEMBER 28, 20003. Time of Death
01:03 A.M.Funeral
Director

4a. Facility Name (If not institution, give street and number)

PUJASKI HIGHWAY AT BELVEDERE ROAD

4b. City, Town, or Location of Death

PERRYVILLE

4c. County of Death

CECIL

5. Social Security Number

213-82-0417

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

25

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 13, 1975

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

239 Hilltop Road

10f. Zip Code

21921

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Stone Hauling

17. Father's Name (First, Middle, Last)

Duane Allen Gibson

18. Mother's Name (First, Middle, Maiden Surname)

Debra Ann Sprout

19a. Informant's Name/Relationship (Type, Print)

Duane A. Gibson/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

239 Hilltop Road, Elkton, Maryland 21921

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cherry Hill Methodist Cemetery

Date

10/2/00

20c. Location - City or Town, State

Cherry Hill, Maryland

21. Signature of Funeral Service Licensee

Dennis J. Chute

22. Name and Address of Facility

Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Multiple Injuries*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

9-28-00

28b. Time of Injury

0050A-M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

pedestrian hit by motor vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Pulaski Highway Cecil Co. Md

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

SEPTEMBER 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Dennis J. Chute

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32254

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN M GROTON

2. Date of Death

Month Day Year
SEPT. 24, 2000

3. Time of Death

5:35 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

SALISBURY Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

222-05-5508

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
January 24, 1920

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 Civic Ave.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

James W. Wright

18. Mother's Name (First, Middle, Maiden Surname)

Sally Joseph

19a. Informant's Name/Relationship (Type, Print)

Richard W. Groton/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 New York Ave., Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Springhill Memory Gardens

Date

9/26/00

20c. Location - City or Town, State

Hebron, MD

21. Signature of Funeral Service Licensee

Kelli R. Ramsey

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

a. Pericardial effusion Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

years

Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

P385 Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner as stated.

29b. Signature and title of certifier

Kelli R. Ramsey MD

29c. License number

039813

29d. Date signed (Month, Day, Year)

9/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MADAMS

1104 HEALTHWAY DR., SALISBURY, MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Sparks

EVELYN GROTON
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32255

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH PAULINE HANSARD

2. Date of Death

Month Day Year
SEPT. 24, 2000

3. Time of Death

2:25 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

229-09-8049

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
SEPT. 6, 1917

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

VA.

10b. County

SHENANDOAH

10c. City, Town or Location

WOODSTOCK

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

935 - OX ROAD

10f. Zip Code

22664

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

KEY PUNCHER

16b. Kind of Business/Industry

NOT AVAILABLE

17. Father's Name (First, Middle, Last)

RUFUS A. WILKINS

18. Mother's Name (First, Middle, Maiden Surname)

TENIE E. HELSLEY

19a. Informant's Name/Relationship (Type, Print)

ALFRED L. HANSARD-SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2128- HERBERT AVE., WESTMINSTER, MD. 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NATIONAL MEM. PARK

Date

9/27/2000-FALLS CHURCH, VA.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hysong Company, Inc.

6510- 16th Street, N.W., Wash., DC

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Seizure

Due to (or as a consequence of):

b. Diabetes mellitus

Due to (or as a consequence of):

c. coronary artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cerebral vascular accident

congestive heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DSA 612

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMUEL G. MALLEZ M.D. National Lutheran Home Rockville Md

31. Date filed (Month, Day, Year)

SEP 26 2000

Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32256

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Lee Hairston				2. Date of Death Month: Sept. Day: 25 Year: 2000				3. Time of Death 23:45	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-16-6164		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 - 90 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1909		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent				10c. City, Town or Location Upper Marlboro				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10e. Street and Number 17136 Fairway View Lane				10f. Zip Code 20772	
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Negro-Indian				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 11th College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker				16b. Kind of Business/Industry Private				17. Father's Name (First, Middle, Last) Unknown	
	18. Mother's Name (First, Middle, Maiden Surname) Unknown				19a. Informant's Name/Relationship (Type, Print) Charles H. Hairston - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Seaton Place, N.W. Wash., D.C. 20001	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee's Crematory		Date 9/30/2000		20c. Location - City or Town, State Clinton, MD		21. Signature of Funeral Service Licensee John T. Stewart III	
	22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Edema Due to (or as a consequence of):		Approximate Interval Between Onset and Death oneday		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, Hypertensive Cardiovascular Disease.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Sam Tellawi		29c. License number D34274	
29d. Date signed (Month, Day, Year) 9.26.2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESSAM Tellawi 7700 Old Branch Ave Clinton, Md 20735		31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature B. Sparks		State Registrar		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32257

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Alease Holbrooks		2. Date of Death Month September Day 17 Year 2000		3. Time of Death 11:20 A.M.	
4a. Facility Name (If not institution, give street and number) Prince George's Community Hospital		4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George	
5. Social Security Number 577-22-3174		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.	
8. Date of Birth (Month, Day, Year) May 5, 1909		9. Birthplace (State or Foreign Country) Virginia			
Usual Residence of Decedent					
10a. State Md		10b. County Prince George		10c. City, Town or Location Forestville	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1902 County Road T2		10f. Zip Code 20747		10g. Citizen of What Country? United States of America	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Waitress		16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Thomas Lewis		18. Mother's Name (First, Middle, Maiden Surname) Sallie Cousins			
19a. Informant's Name/Relationship (Type, Print) Alease Terry Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 County Road T2 Forestville Maryland 20747			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		20c. Location - City or Town, State 9-22-2000 Beltsville, Maryland	
21. Signature of Funeral Service Licensee Glenda M. Freeman		22. Name and Address of Facility Robert O. Freeman Funeral Services 1353 H Street N.E. Washington D.C. 20002			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. metastatic cancer of colon Due to (or as a consequence of): b. Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death months YIS			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Glenda M. Freeman		29c. License number 041978	
29d. Date signed (Month, Day, Year) 9-17-2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nader Jawakoli 1 Hosp St Cheverly MD 20783					
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32258

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Julia Ersie Henderson						2. Date of Death Month Day Year September 25 2000		3. Time of Death 1405 P	
	4a. Facility Name (If not institution, give street and number) Union Hospital				4b. City, Town, or Location of Death Elkton		4c. County of Death Cecil			
Funeral Director	5. Social Security Number 199-05-8009		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) OCT 14, 1906		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Cecil		10c. City, Town or Location Rising Sun				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 1881 Telegraph Road				10f. Zip Code 21911		10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry In Own Home			
17. Father's Name (First, Middle, Last) Robert Ingram						18. Mother's Name (First, Middle, Maiden Surname) Jane Davis				
19a. Informant's Name/Relationship (Type, Print) Julia E. Henderson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1881 Telegraph Road, Rising Sun, Maryland 21911						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery		Date 9/29/00		20c. Location - City or Town, State Darlington, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CVA Due to (or as a consequence of): b. CAD Atrial Fibrillation Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 		29c. License number D26183		
29d. Date signed (Month, Day, Year) 09-28-00						30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHU SACHDEV MD 118 North St, ELKTON, md 21921				
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32259

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LeeVarn Johnson				2. Date of Death Month Day Year Sept. 20 2000				3. Time of Death 3:58PM	
	4a. Facility Name (If not institution, give street and number) Doctors Hospital				4b. City, Town, or Location of Death Lanham				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 334-42-8761		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 7, 1949		9. Birthplace (State or Foreign Country) Mississippi	
	Usual Residence of Decedent				10c. City, Town or Location Lanham		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10e. Street and Number 9322 Bandera St.		10f. Zip Code 20706		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Supervisor		16b. Kind of Business/Industry Private					
	17. Father's Name (First, Middle, Last) Robert Johnson				18. Mother's Name (First, Middle, Maiden Surname) Velma Levy					
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Nettie R. Johnson - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9322 Bandera St., Lanham, MD 20706					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glenwood Cemetery		Date 9/27/2000		20c. Location - City or Town, State Wash., D.C.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Renal Disease Diabetes Mellitus, Hypertension Hepatitis C, Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease Diabetes Mellitus, Hypertension Hepatitis C,						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D48213		29d. Date signed (Month, Day, Year) 09-21-2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashar 4410 74th Ave Landover Hills MD 20784									
	31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 							

ADH

JEROME JONES

00-5554-033

amend item 23a, pt II, 27 per me G788 10/17/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32260

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEROME E. JONES

2. Date of Death

Month Day Year
OCTOBER 1, 2000

3. Time of Death

1101 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

4804 RODGERS DRIVE

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578-72-9020

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 9, 1955

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4804 Rodgers Avenue

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1976-

1979-

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Mail Handler

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

Roosevelt Jones

18. Mother's Name (First, Middle, Maiden Surname)

Loretta Medley

19a. Informant's Name/Relationship (Type, Print)

Darlene Jones - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1348 Canal Street S.W., Washington DC 20024

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cem

Date

10-10-2000 Cheltenham, MD

21. Signature of Funeral Service Licensee

Julia P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

OCTOBER 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. King

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

OCT 05 2000

32. Registrar's Signature

Betsy B. Sparks

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32261

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LILLIAN TOBACK JACOBS		2. Date of Death Month Day Year September 27, 2000		3. Time of Death 11:00 AM
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 119-07-3837	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	8. Date of Birth (Month, Day, Year) February 4, 1916	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 300 Lemmon Hill		10f. Zip Code 21801		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) -		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk
	16b. Kind of Business/Industry Office		17. Father's Name (First, Middle, Last) Charles Topack		18. Mother's Name (First, Middle, Maiden Surname) Rose Cohen
	19a. Informant's Name/Relationship (Type, Print) Ilene A. Richardson/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Kipling Dr., Salisbury, MD 21801		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State Salisbury, MD
	21. Signature of Funeral Service Licensee MO1051 David H. Thompson		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) C. Difficile Colitis		Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease		Approximate Interval Between Onset and Death 7 Days.
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):		
			Due to (or as a consequence of):		
			Due to (or as a consequence of):		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Inflammatory Polyneuropathy				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				
28a. Date of Injury (Month, Day, Year)					
28b. Time of Injury M					
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier H. Moon		29c. License number D32014		29d. Date signed (Month, Day, Year) 9-27-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHESH MOON DRA 106 MILFORD ST 504 B SALISBURY MD 21804					
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32262

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

James Thomas Jernigan

2. Date of Death
Month Day Year
September 26, 20003. Time of Death
12:20PM

4a. Facility Name (If not institution, give street and number)

22159 Knight Court

4b. City, Town, or Location of Death

Lexington Park

4c. County of Death

St. Mary's

5. Social Security Number

247-78-7082

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 25, 1947

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22159 Knight Court

10f. Zip Code

20653

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1964-1970

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Auto Body Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Willis James Jernigan, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Kathryn Ruth Young

19a. Informant's Name/Relationship (Type, Print)

Nancy B. Jernigan, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22159 Knight Court, Lexington Park,

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

9/29/00

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Funeral Service

1601 Kenilworth Avenue, Washington, DC 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LARYNGEAL CARCINOMA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40370

29d. Date signed (Month, Day, Year)

9/28/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Peter Wisniewski 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32263

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shizue Y. Keeran				2. Date of Death Month September Day 17 Year 2000				3. Time of Death 0145		
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Chesley				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 228 72 3155		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Sept 5, 1915		9. Birthplace (State or Foreign Country) Japan		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County P.G.		10c. City, Town or Location Forestville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 1511 Asheville Road				10f. Zip Code 20747		10g. Citizen of What Country? United States				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Japanese			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Homemaker			
	17. Father's Name (First, Middle, Last) Sotaro Yamazawa				18. Mother's Name (First, Middle, Maiden Surname) Fusa (UNKNOWN)						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Toshi Wildfeuer (POA)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Asheville Road, Forestville, Maryland 20747						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery			20c. Location - City or Town, State Arlington, Virginia			
	21. Signature of Funeral Service Licensee SK S. S.				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
State Registrar	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier Salvador S. S.				29c. License number H2055927		29d. Date signed (Month, Day, Year) September 20, 2000				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Salvador S. S. 3001 Hospital Drive, Chesley, Maryland 20735											
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32264

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) METTIE C. KINGSTON				2. Date of Death Month 09 Day 23 Year 2000				3. Time of Death 7:30 am	
	4a. Facility Name (If not Institution, give street and number) 1011 DANBURY DRIVE				4b. City, Town, or Location of Death BOWIE				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 585-26-4341		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 06/28/1905		9. Birthplace (State or Foreign Country) KENTUCKY		10e. State MD.		10b. County PRINCE GEORGES		10c. City, Town or Location BOWIE	
Usual Residence of Decedent		10d. Inside City Limits XX Yes 2 <input type="checkbox"/> No		10e. Street and Number 1011 DANBURY DRIVE		10f. Zip Code 20721		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOMEMAKER		17. Father's Name (First, Middle, Last) J.K. WALKER		18. Mother's Name (First, Middle, Maiden Surname) ANNIE STEPHENS		19. Informant's Name/Relationship (Type, Print) BILL KINGSTON/GRANDSON		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET MEMORIAL PARK		20c. Location - City or Town, State ALBUQUERQUE, NM		21. Signature of Funeral Service Licensee KYLE SIMONS M01206		22. Name and Address of Facility BEALL FUNERAL HOME 6512 N.W. CRAIN HWY. BOWIE, MD. 20715		
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 9/28/2000		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William DuBoyce		
29c. License number 047603		29d. Date signed (Month, Day, Year) 09/25/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William DuBoyce, MD, 4000 Mitchellville Rd., Bowie, Md. 20716		31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature P. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32265

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN V. KNOTT

2. Date of Death

Month Day Year
SEPT. 23, 2000

3. Time of Death

3:35 am

4a. Facility Name (If not institution, give street and number)

4901 NICHOLSON STREET

4b. City, Town, or Location of Death

RIVERDALE

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

577 26 1116

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 21, 1923

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Riverdale

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4901 Nicholson St.

10f. Zip Code

20737

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

John Fowler

18. Mother's Name (First, Middle, Maiden Surname)

Helen Virginia Shenk

19a. Informant's Name/Relationship (Type, Print)

John F. Knott spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as 10e

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ft. Lincoln Cemetery Sept. 25, 2000 Brentwood, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home
16000 Annapolis Rd., Bowie, Md. 2071523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. metastatic lung cancer.

Due to (or as a consequence of)

Approximate
Interval Between
Onset and Death

≈ 6 months.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury et
Work?☐ Yes ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

0101053020

29d. Date signed (Month, Day, Year)

9/24/00.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12255 Fairlakes Parkway VA.

22033.

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32266

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen C. Kostic				2. Date of Death Month Day Year September 28, 2000				3. Time of Death 4:15 AM						
	4a. Facility Name (If not institution, give street and number) Sunbridge Care Center				4b. City, Town, or Location of Death Elkton				4c. County of Death Cecil						
Funeral Director	5. Social Security Number 206-24-7270		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) November 18, 1917		9. Birthplace (State or Foreign Country) Pennsylvania						
	Usual Residence of Decedent				10a. State Maryland				10b. County Cecil		10c. City, Town or Location North East				
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 77 Kirks Mill Lane				10f. Zip Code 21901		10g. Citizen of What Country? United States				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry In her own home						
	17. Father's Name (First, Middle, Last) Joseph Moore				18. Mother's Name (First, Middle, Maiden Surname) Susan Kane										
	19a. Informant's Name/Relationship (Type, Print) Arlene McCloskey / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 77 Kirks Mill Lane, North East, Maryland 21901										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ss. Peter and Paul Cemetery				20c. Date October 3, 2000						
	20d. Location - City or Town, State Springfield, Pennsylvania				21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Oliver H. Bair Companies, 8500 West Chester Pike Upper Darby, Pennsylvania 19082						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Cerebrovascular Accident Due to (or as a consequence of): d. 				Approximate Interval Between Onset and Death										
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D26183				29d. Date signed (Month, Day, Year) 09-28-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhu SACHDEV, M.D. 118 North St, ELKton, md. 21921				31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

00 32267

REPLACEMENT

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stanley Eugene Koppenhaver				2. Date of Death Month Day Year August 18, 2000		3. Time of Death 2115	
	4a. Facility Name (If not institution, give street and number) Dorchester Memorial Hospital				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 171-20-6164		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 17, 1925	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Dorchester		10c. City, Town or Location Cambridge	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1446 Cambridge Beltway		10f. Zip Code 21613		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 43 - 46		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tool & Die Machinist		16b. Kind of Business/Industry Western Electric		17. Father's Name (First, Middle, Last) Unknown		
18. Mother's Name (First, Middle, Maiden Surname) Unknown		19a. Informant's Name/Relationship (Type, Print) Krisfield F. Koppenhaver/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1446 Cambridge Beltway, Cambridge, MD 21613		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) East. Shore Veterans Cem.		Date 8/21/00		20c. Location - City or Town, State Hurlock, Maryland		21. Signature of Funeral Service Licensee Michael F. Eskow per DVR		
22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Aortic Aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 24 hr		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William Bair		29c. License number D43235		
29d. Date signed (Month, Day, Year) August 21, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Bair 19 Franklin St. Cambridge, MD 21613		31. Date filed (Month, Day, Year) Oct 11 2000		32. Registrar's Signature B. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32268

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS ANGELO LOZUPONE, JR.				2. Date of Death Month Day Year SEPT. 22, 2000				3. Time of Death 10:10pm	
	4a. Facility Name (If not institution, give street and number) 2250 FLAG COURT				4b. City, Town, or Location of Death ODENTON				4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 578 54 8070		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Jan. 17, 1941		9. Birthplace (State or Foreign Country) Washington, DC		10a. State Md.		10b. County Anne Arundel		10c. City, Town or Location Odenton	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
10e. Street and Number 2250 Flag Court										
10f. Zip Code 21113										
10g. Citizen of What Country? USA										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0										
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fireman										
16b. Kind of Business/Industry DC Fire Dept.										
17. Father's Name (First, Middle, Last) Louis Angelo Lozupone										
18. Mother's Name (First, Middle, Maiden Surname) Gilda Pace										
19a. Informant's Name/Relationship (Type, Print) Jacqueline Lozupone spouse same as 10e										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery Sept. 25, 2000 Washington DC										
20c. Location - City or Town, State										
21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home, 16000 Annapolis RD., Bowie, Md. 20715										
22. Name and Address of Facility										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE MYELOGENOUS LEUKEMIA										
Approximate Interval Between Onset and Death 1 YEAR										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year)										
28b. Time of Injury M										
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Lance K. Lassiter										
29c. License number D0056099										
29d. Date signed (Month, Day, Year) 9/23/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANCE K. LASSITER, 401 N. BROADWAY, BALTIMORE, MD 21231										
31. Date filed (Month, Day, Year) SEP 26 2000										
32. Registrar's Signature B. Spaul										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

CHARLENE YVONNE LOVELY

amend item 23a, 27 per me G790 12/12/00 yf

Certificate of Death

Reg. No.

00 32269

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charlene Yvonne Lovely		2. Date of Death Month SEPT Day 30 Year 2000		3. Time of Death 2236 PM
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL		4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 212-08-5525	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 27, 1968		9. Birthplace (State or Foreign Country) Washington, D.C.		
Usual Residence of Decedent					
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location New Carrollton	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 5406 - 85th Avenue, Apt. 22		10f. Zip Code 20784		10g. Citizen of What Country? United States	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Program Specialist		16b. Kind of Business/Industry St. John's Community Services	
17. Father's Name (First, Middle, Last) Willie Lovely, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Vivian Cornelia Green			
19a. Informant's Name/Relationship (Type, Print) Cynthia Ann Lovely (Sister)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5334 - 85th Avenue, Apt. C-2; New Carrollton, Maryland 20784			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland	
20d. Date Oct. 5, 2000					
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility R. N. Horton Company Morticians, Inc. 600 Kennedy Street, N.W.; Washington, D.C. 20011			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. CARDIAC ARRYTHMIA ASSOCIATED WITH MITRAL VALVE PROLAPSE					
Due to (or as a consequence of):					
b. Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 1, 2000	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

100-212-1000

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RE

TO

FROM

DATE

BY

REMARKS

100-212-1000

OFFICE OF THE ATTORNEY GENERAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32270

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CAROLYN DONNELLY LYDDANE				2. Date of Death Month Day Year September 28, 2000		3. Time of Death 01:00AM	
	4a. Facility Name (If not institution, give street and number) 6012 New Forest Court				4b. City, Town, or Location of Death Waldorf		4c. County of Death Charles	
Funeral Director	5. Social Security Number 579-22-6372		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 7, 1924	
	9. Birthplace (State or Foreign Country) Washington, D.C.							
Usual Residence of Decedent								
10a. State Maryland		10b. County Charles		10c. City, Town or Location Waldorf			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 6012 New Forest Court, Apt#1				10f. Zip Code 20603		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Dentist	
17. Father's Name (First, Middle, Last) James David Donnelly					18. Mother's Name (First, Middle, Maiden Surname) Bessie Birch			
19a. Informant's Name/Relationship (Type, Print) Joseph A. Lyddane/Husband					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6012 New Forest Court, Apt.1, Waldorf, MD 20603			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Ignatius Cemetery			20c. Location - City or Town, State Chapel Point, MD		
21. Signature of Funeral Service Licensee MARK G. BROHAWN M00053			22. Name and Address of Facility The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of Liver Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner			29b. Signature and title of certifier Krishan Mathur, MD.					
			29c. License number D28352			29d. Date signed (Month, Day, Year) September 28, 2000		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646								
31. Date filed (Month, Day, Year) OCT 02 2000			32. Registrar's Signature B. Sparks					

ORIGINAL

Joseph David Linton

amend item 23a,27, 28a,b,c,d,e,f per me G788 10/25/00

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32271

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph David Linton				2. Date of Death Month Day Year October 07, 2000				3. Time of Death 1030 am	
	4a. Facility Name (If not institution, give street and number) 10111-B Clemsonville Road				4b. City, Town, or Location of Death Union Bridge				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-84-3589	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 3, 1962		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Union Bridge				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 10111-B Clemsonville Rd.				10f. Zip Code 21791		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HVAC technician				16b. Kind of Business/Industry county gov't.		
17. Father's Name (First, Middle, Last) Joseph Martin Linton				18. Mother's Name (First, Middle, Maiden Surname) Barbara E. Fogle						
19a. Informant's Name/Relationship (Type, Print) Karen D. Linton/ wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819C Stratford Dr. Frederick, MD 21701						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Methodist Cemetery		Date 10/12/00		20c. Location - City or Town, State Johnsville, MD		
21. Signature of Funeral Service Licensee Catherine O. Hartzler				22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GUNSHOT WOUND OF HEAD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene						
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) found: 10/7/00		28b. Time of Injury found: 10:10 A M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred subject shot self				28e. Location (Street and Number or Rural Route Number, City or Town, State) 10111-B, Clemsonville Road Union Bridge, Maryland		
28f. Location (Street and Number or Rural Route Number, City or Town, State) found: residence										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier J. A. Linton				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) October 08, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) OCT 11 2000				32. Registrar's Signature Geneva B Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32272

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WANDA P. LEWIS				2. Date of Death Month Day Year Sept. 26. 2000		3. Time of Death 4:05 AM	
	4e. Facility Name (If not institution, give street and number) Salisbury Center; Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, Md		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 215-16-3964		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 10, 1925	
	9. Birthplace (State or Foreign Country) DELAWARE		10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6112 STEVE STREET		10f. Zip Code 21804		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECHNICIAN		16b. Kind of Business/Industry PHARMACEUTICAL			
	17. Father's Name (First, Middle, Last) UNKNOWN		18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN		19a. Informant's Name/Relationship (Type, Print) LLOYD W. LEWIS/HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6112 STEVE STREET, SALISBURY, MARYLAND 21804	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NEW HOPE CEMETERY		20c. Date 9/29/00		20d. Location - City or Town, State WILLARDS, MARYLAND	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. <u>CIRRHOSIS</u> Due to (or as a consequence of): f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death YEARS	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number D39813	
	29d. Date signed (Month, Day, Year) SEP 28 2000		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804		31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 	

ORIGINAL

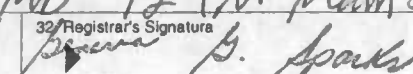
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32273

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES EDWIN LAWHON				2. Date of Death Month September Day 28 , Year 2000				3. Time of Death 2:45 PM	
	4a. Facility Name (If not institution, give street and number) 28166 PATHFINDER COURT				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 579-26-4666	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 6, 1925		9. Birthplace (State or Foreign Country) Florida		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 28166 Pathfinder Court				10f. Zip Code 21801		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookbinder Supervisor			16b. Kind of Business/Industry Printing			
	17. Father's Name (First, Middle, Last) Phillip Greene Lawhon				18. Mother's Name (First, Middle, Maiden Surname) Norene M. Johnson					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Alma E. Lawhon/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28166 Pathfinder Court, Salisbury, MD 21801					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Data 10/2/00		20c. Location - City or Town, State Salisbury, MD			
	21. Signature of Funeral Service Licensee 		M01051		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma Unknown Primary Unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D-35764		29d. Date signed (Month, Day, Year) 9/29/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bill Greer, MD 124 N. Main St. Berlin, MD 21811										
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32274

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Jeffrey Frank Lamb		2. Date of Death Month Day Year SEPTEMBER 22, 2000		3. Time of Death 23:28 PM	
4a. Facility Name (If not institution, give street and number) ROUTE 301 and ROUTE 227		4b. City, Town, or Location of Death White Plains		4c. County of Death CHARLES	
5. Social Security Number 215-88-4029	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 27, 1966
9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent			
10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Lexington Park		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2189 Sidney Drive		10f. Zip Code 20653		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Collega (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Lumber Yard			
17. Father's Name (First, Middle, Last) Walter B. Lamb		18. Mother's Name (First, Middle, Maiden Surname) Nancy Carolyn Lam			
19a. Informant's Name/Relationship (Type, Print) Walter Allan Lamb, brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26933 Mechanicsville Road, Mechanicsville, Maryland, 20659			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gardens		20c. Location - City or Town, State 9/27/00 Great Mills, Maryland	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Sterling Funeral Service 1601 Kenilworth Avenue, Washington, DC			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 9/22/00		28b. Time of Injury 11:13 PM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred PEDESTRIAN STRUCK BY AUTO		28e. Location (Street and Number or Rural Route Number, City or Town, State) ROUTE 301 SOUTH WHITE PLAINS, MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number OCME	
29d. Date signed (Month, Day, Year) SEPTEMBER 23, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TRUS, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature <i>[Signature]</i>			

259 30 100 0 932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32275

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert McNab				2. Date of Death Month Day Year September 24, 2000				3. Time of Death 12:25 PM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578 42 1222		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 24, 1933		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent				10c. City, Town or Location Ft. Washington		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10e. Street and Number 6801 Janet Lane		10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Grocery					
	17. Father's Name (First, Middle, Last) Wallace McNab				18. Mother's Name (First, Middle, Maiden Surname) Norma Schwartzman					
	19a. Informant's Name/Relationship (Type, Print) Brenda Lee Shaffer (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 Kirby Road Clinton, Maryland 20735					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory		Date Sept. 28, 2000		20c. Location - City or Town, State Clinton, Maryland			
	21. Signature of Funeral Service Licensee <i>Louis L. Shant</i>				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myo. Infarction Due to (or as a consequence of): b. Cardiogenic Shock Due to (or as a consequence of): c. CHF Due to (or as a consequence of): d. HTN COAD Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PCP Rx								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D 24208		29d. Date signed (Month, Day, Year) 9.24.2000						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ABULHASAN U ANSARI		8926 Woodyard Rd # 101 Clinton Md. 20735								
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature <i>[Signature]</i>								

James H. H. H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32276

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TARA MEHROTRA				2. Date of Death Month Day Year September 24, 2000				3. Time of Death 3:30 PM		
	4a. Facility Name (If not institution, give street and number) 605 Venice Drive				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery County		
Funeral Director	5. Social Security Number None		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) March 16, 1923		9. Birthplace (State or Foreign Country) India		
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number 605 Venice Drive		10f. Zip Code 20904		10g. Citizen of What Country? India							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian/Indian					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4or 5+) -		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Har Narain Tandon				18. Mother's Name (First, Middle, Maiden Surname) Dulari Devi							
19a. Informant's Name/Relationship (Type, Print) Avadh B. Mehrotra - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Venice Drive-Silver Spring, Maryland 20904							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Northern Va. Crematory		Date 9/25/00		20c. Location - City or Town, State Arlington, Virginia			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Arlington Funeral Home-Arlington, Va. 22203 3901 North Fairfax Drive							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finest disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): coronary artery disease Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death months			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D42403		29d. Date signed (Month, Day, Year) 9-24-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJ MATHUR 106 IRVING STREET, NW WASHINGTON D.C 20010											
31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature 							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 32277

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CONSTANCE MOORE				2. Date of Death Month Day Year SEPTEMBER 25, 2000				3. Time of Death 7:30am			
	4a. Facility Name (If not institution, give street and number) 502 COSTE CT.				4b. City, Town, or Location of Death FORT WASHINGTON				4c. County of Death PRINCE GEORGES			
Funeral Director	5. Social Security Number 579-50-9544		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) April 6, 1937		9. Birthplace (State or Foreign Country) Washington, D.C.			
	Usual Residence of Decedent				10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Ft. Washington			
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 502 Coste Ct.				10f. Zip Code 20744			
	10g. Citizen of What Country? United States				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Assistant				16b. Kind of Business/Industry Private				17. Father's Name (First, Middle, Last) Benjamin Foster			
	18. Mother's Name (First, Middle, Maiden Surname) Rosalind Newman				19a. Informant's Name/Relationship (Type, Print) Rosalind Jenkins/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11110 Lake Arbor Way Mitchellville, Md. 20721			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Cem. 9/29/00				20c. Location - City or Town, State Laurel, Md.			
	21. Signature of Funeral Service Licensee Kathleen M. Jones M01085				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. METASTATIC LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Stephen Stark MD				29c. License number D18219			
	29d. Date signed (Month, Day, Year) 09/27/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN STARK 1221 MERCANTILE LN CARGO MD 20774				31. Date filed (Month, Day, Year) SEP 28 2000			
	32. Registrar's Signature [Signature]				33. Registrar's Title [Signature]				34. Registrar's Name [Signature]			

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State of Maryland / Department of Health and Mental Hygiene

00 32278

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma L. Martin				2. Date of Death Month Day Year Sept. 24 2000		3. Time of Death 11:50 A.M.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578 24 0779		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 28, 1925	
	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Seabrook		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 6904 Lyle Street				10f. Zip Code 20706		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Howard Devers				18. Mother's Name (First, Middle, Maiden Surname) Charlotte Minder				
19a. Informant's Name/Relationship (Type, Print) Linda K. Perry Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6904 Lyle Street Seabrook Maryland 20706				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens		20c. Location - City or Town, State Davidsonville MD		
21. Signature of Funeral Service Licensee Robert E. Evans				22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Rd. Bowie Maryland 20715				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① END STAGE EMPHYSEMA WITH HYPOXIA ② POSSIBLE SEPSIS ③ CHRONIC ADRENAL INSUFFICIENCY ④ CARDIOMEGALY ⑤ MYASTHENIC GRAVIS HISTORY				Approximate Interval Between Onset and Death
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Mohammed A. Manna				29c. License number D24593
29d. Data signed (Month, Day, Year) 9.26.00								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED A. MANNA MD, 3331- TOLBDO TERRACE HYATTSVILLE, MD. 20782								
31. Data filed (Month, Day, Year) SEP 29 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

217.3.37

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32279

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Catherine Muller

2. Date of Death

Month Day Year
SEPTEMBER 26 2000

3. Time of Death

3:20 AM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

077-09-3188

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 27, 1909

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Lanham

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9885 Greenbelt Road

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

FREDERICK DRODGE

18. Mother's Name (First, Middle, Maiden Surname)

GERTRUDE MUNZ

19a. Informant's Name/Relationship (Type, Print)

RONALD M. MULLER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9904 FRANK TIPPETT ROAD, UPPER MARLBORO, 20772

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PINE LAWN CEMETERY

SEPT 29, 2000

20c. Location - City or Town, State

LONG ISLAND, NEW YORK

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LEE FUNERAL HOME, INC 6633 OLD

ALEXANDRIA FERRY ROAD, CLINTON, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

PARTIAL COLECTOMY

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DPINDER SINGH, MD 14300 GAWANT FOX LANE, BOWIE, MD 20715

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

B. Spawls

State
Registrar

ORIGINAL

RUTH CATHERINE MULLER
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32280

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Gladys F. McAllister

2. Date of Death
Month Day Year

September 15, 2000

3. Time of Death
2030

4a. Facility Name (If not institution, give street and number)

18606 Constance Court

4b. City, Town, or Location of Death

Accokeek

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-52-4527

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

2/4/24

9. Birthplace (State or Foreign Country)

Lilliton, SC

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Accokeek

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18606 Constance Court

10f. Zip Code

20607

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Baddie Boyd

18. Mother's Name (First, Middle, Maiden Surname)

Pearlie Campbell

19a. Informant's Name/Relationship (Type, Print)

Patricia Britton daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18606 Constance Ct., Accokeek, MD 20607

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

9/21/00

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Ava J. McKell

22. Name and Address of Facility

Pope Funeral Home

5538 Marlboro Pike, FV, MD 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Salvador Sylvester, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

September 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester, 3001 Hospital Drive, Chevy Chase, Maryland 20775

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Spivey

State
Registrar

Baltimore, Maryland 21215-0020

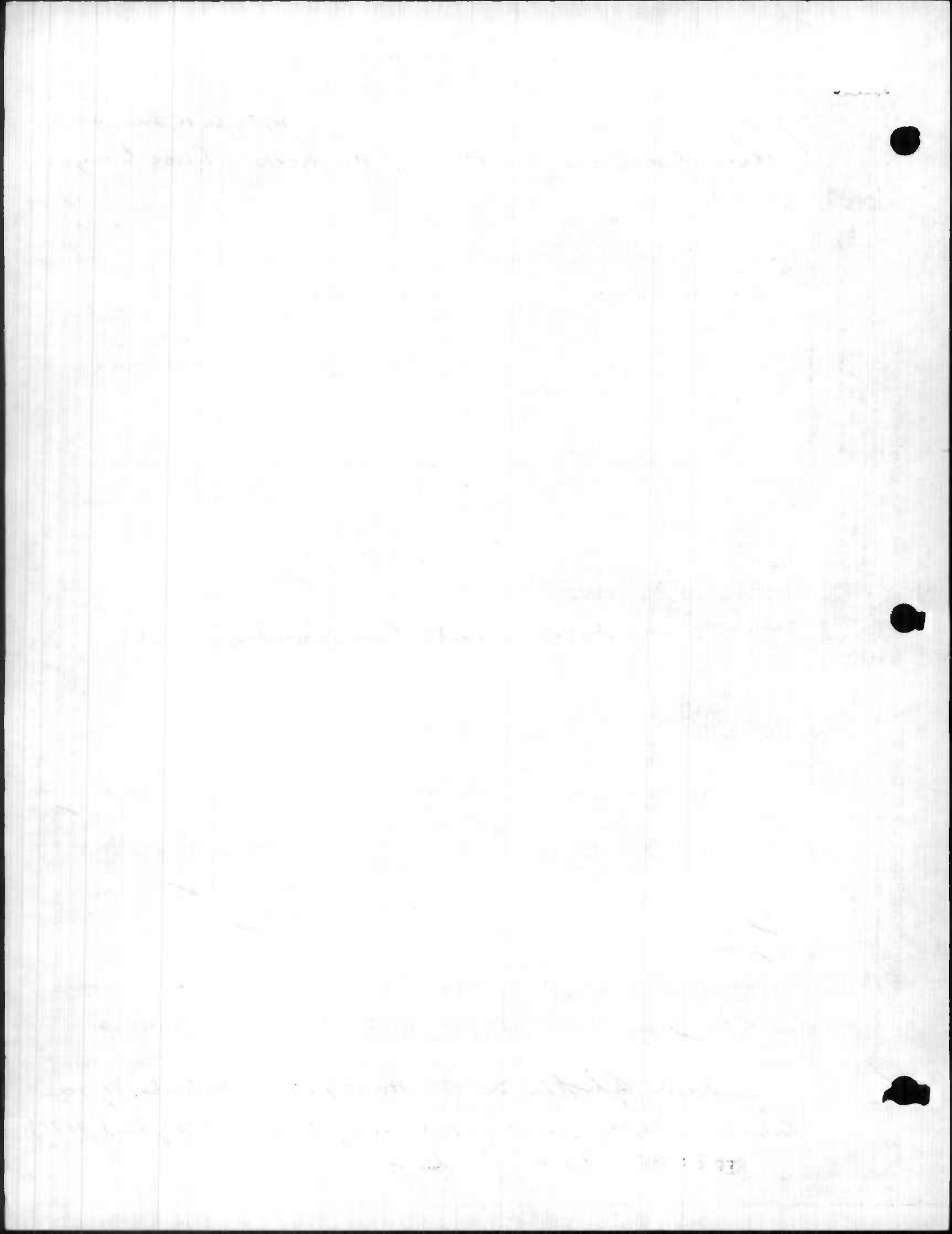
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32281

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Susan Moskal				2. Date of Death Month: Sept. Day: 29, Year: 2000				3. Time of Death 11:50 AM	
	4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death LaPlata				4c. County of Death Charles	
Funeral Director	5. Social Security Number 220-40-7077		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) 10-10-1942		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent		10a. State Maryland		10b. County Charles		10c. City, Town or Location Indian Head		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 35 Highland Place		10f. Zip Code 20640		10g. Citizen of What Country? United States						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Real Estate Company				
17. Father's Name (First, Middle, Last) Lomax B. Rhodes				18. Mother's Name (First, Middle, Maiden Surname) Helen Sprague						
19a. Informant's Name/Relationship (Type, Print) Robert W. Gilroy/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1603 Debra Drive, Waldorf, Maryland 20601						
20a. Method of Disposition X <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 10-05-		20c. Location - City or Town, State 2000 Cheltenham, Maryland				
21. Signature of Funeral Service Licensee 		M00668		22. Name and Address of Facility Williams Funeral Home 4270 Hawthorne Road, Indian Head, Maryland				20640		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Hepato-Renal Syndrome Due to (or as a consequence of): b. Liver Failure Due to (or as a consequence of): c. Cirrhosis of Liver Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 Week				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number D-000295		29d. Date signed (Month, Day, Year) September 29, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel M. Howell, M.D. 605 E. Charles Street P.O. Box 1488 LaPlata, MD 20646										
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32282

Amend Item #26 as per Physician 10/10/00 cche

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry Monk Jr.		2. Date of Death Month September Day 29 Year 2000		3. Time of Death 9:25 pm
	4a. Facility Name (If not institution, give street and number) Genesis Elder Care		4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles
Funeral Director	5. Social Security Number 247-46-1933	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 7, 1933		9. Birthplace (State or Foreign Country) South Carolina		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Charles		10c. City, Town or Location LaPlata
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number 5795 Bumpy Oak Rd		10f. Zip Code 20646		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self-Employed		16b. Kind of Business/Industry Carpenter	
17. Father's Name (First, Middle, Last) Henry Monk Sr.			18. Mother's Name (First, Middle, Maiden Surname) Ardelia Nivens Monk		
19a. Informant's Name/Relationship (Type, Print) Janet Pugh/Step- Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Dalewood Rd, Ft. Washington MD 20744		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smith Chapel Cemetery		Date 10/5/00	20c. Location - City or Town, State La Plata, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility M191 Adams Funeral Home P.A. Aquasco MD 20608			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. LARYNGEAL CANCER with METASTASIS Due to (or as a consequence of): c. PNEUMONIA Bilateral Due to (or as a consequence of): d. Decomente, Alzheimer's					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paraphyric					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D0053219	29d. Date signed (Month, Day, Year) 10-2-2000
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Zafar A. Ansari, M.D. 8926 Woodyard Rd suite 101 Clinton, MD 20735					
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

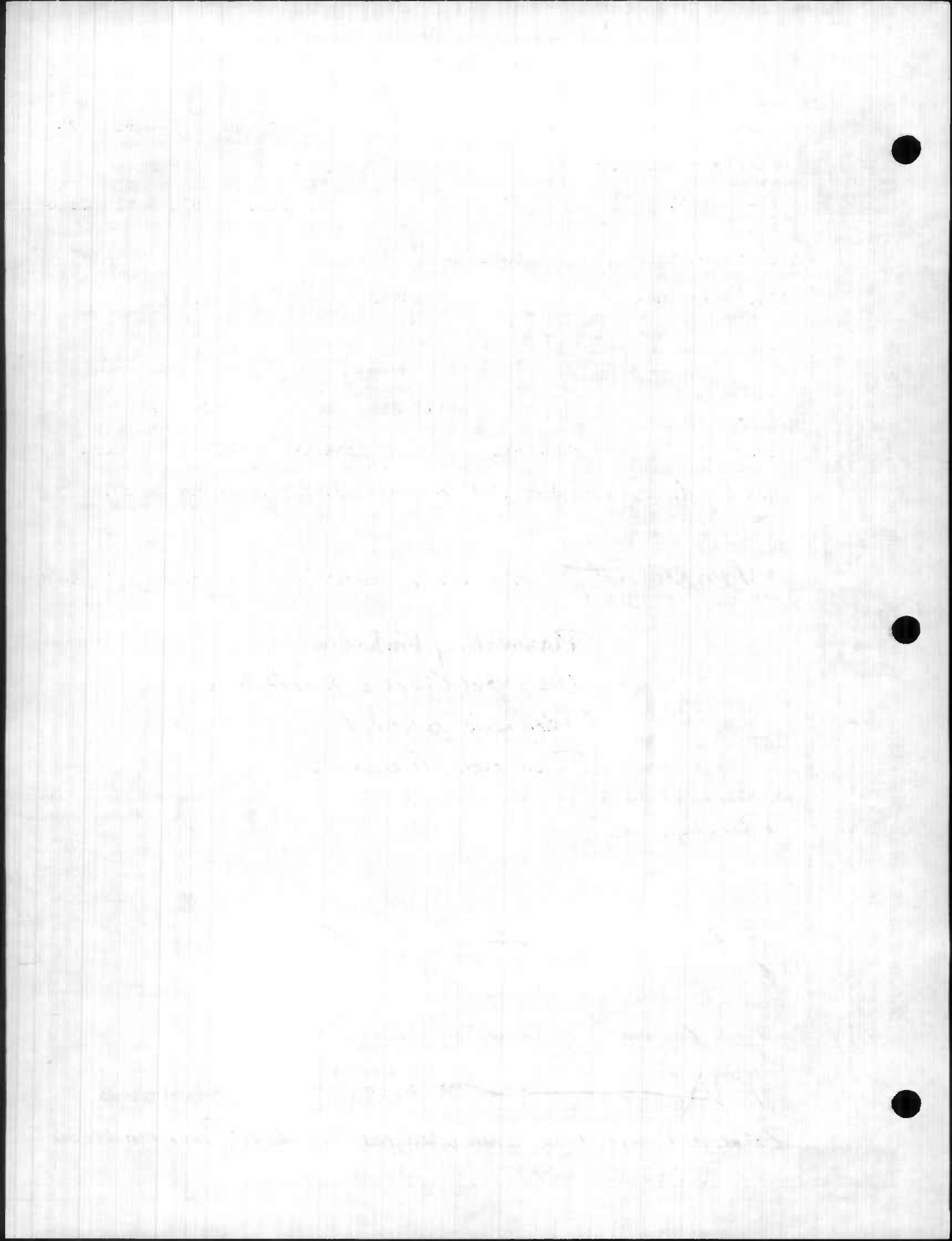
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32283

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BARBARA L. MAGIN				2. Date of Death Month Day Year SEPT. 27, 2000		3. Time of Death 5:00 AM	
	4a. Facility Name (If not institution, give street and number) 309 SUNSHINE WAY				4b. City, Town, or Location of Death WESTMINSTER		4c. County of Death CARROLL	
Funeral Director	5. Social Security Number 215-32-4856		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 6/21/36	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD.		10b. County CARROLL		10c. City, Town or Location WESTMINSTER	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 309 SUNSHINE WAY		10f. Zip Code 21157	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STORE OWNER				16b. Kind of Business/Industry GENERAL STORE			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) EARL S. KREBS				18. Mother's Name (First, Middle, Maiden Surname) BERYL GAMBER			
	19a. Informant's Name/Relationship (Type, Print) RONALD W. MAGIN -HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 SUNSHINE WAY, WESTMINSTER, MD. 21157			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOW BRANCH CEM.		20c. Location - City or Town, State WESTMINSTER, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. metastatic colon cancer				Approximate Interval Between Onset and Death 18 months			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Thomas K. Galvin III			
	29c. License number 031660				29d. Date signed (Month, Day, Year) 09/28/2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS K. GALVIN III MD 291 STONER AVENUE WESTMINSTER, MD 21157				31. Date filed (Month, Day, Year) SEP 29 2000			
	32. Registrar's Signature 				33. Date signed (Month, Day, Year)			

North Pacific Color Change

X

X

X

X

10/22/2000

10/22/2000

10/22/2000

10/22/2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32284

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Daniel Joseph Mulqueen III</i>				2. Date of Death Month <i>September</i> Day <i>28</i> Year <i>2000</i>				3. Time of Death <i>1715</i>	
	4a. Facility Name (If not institution, give street and number) <i>Union Hospital</i>				4b. City, Town, or Location of Death <i>Elkton</i>				4c. County of Death <i>Cecil</i>	
Funeral Director	5. Social Security Number <i>202-18-1180</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>74</i> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <i>July 22, 1926</i>		9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>		10a. State <i>Maryland</i>		10b. County <i>Cecil</i>		10c. City, Town or Location <i>North East</i>	
Usual Residence of Decedent										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number <i>327 Old Bayview Road</i>				10f. Zip Code <i>21901</i>				10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Highway Foreman</i>				16b. Kind of Business/Industry <i>Highway Administration</i>		
17. Father's Name (First, Middle, Last) <i>Daniel Joseph Mulqueen, Jr.</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Madeline Elizabeth Schatz</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Michael Daniel Mulqueen</i>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>53 Concord Rd. #27 Aston, PA 19014</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arlington Cemetery</i>				Date <i>10-6-00</i>		20c. Location - City or Town, State <i>Drexel Hill, PA</i>
21. Signature of Funeral Director <i>Rochelle R. Nichols</i>				22. Name and Address of Facility <i>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)										
a. <i>Acute myocardial infarction</i> Due to (or as a consequence of):										
b. <i>Coronary Artery Disease</i> Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Approximate Interval Between Onset and Death <i>12 Hours</i> <i>2 years</i>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Monte Makows, MD</i>						29c. License number <i>D-44783</i>		29d. Date signed (Month, Day, Year) <i>September 29, 00</i>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>MONTA MAKOWS, MD 111 West High Street, ELKTON, MD 21921</i>										
31. Date filed (Month, Day, Year) <i>OCT 03 2000</i>						32. Registrar's Signature <i>B. Sparks</i>				

ORIGINAL

Chas. S. Smith

1000 1/2 N. 1st St.
St. Paul, Minn.

1000

1000 1/2 N. 1st St.

1000 1/2 N. 1st St. St. Paul, Minn.

1000 1/2 N. 1st St.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32285

Amended #9, 09/27/2000, WCHD, HLC

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>CLIFTON MITCHELL</u>				2. Date of Death Month <u>09</u> Day <u>21</u> Year <u>00</u>		3. Time of Death <u>6:00 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>GEC - RANOMASTOWN</u>				4b. City, Town, or Location of Death <u>RANOMASTOWN</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>212161843</u>		6. Sex <u>1</u> Male <u>2</u> Female		7. Age (In yrs. last birthday) <u>85</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>10-20-14</u>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <u>USA</u>		10. Inside City Limits <u>1</u> Yes <u>2</u> No			
10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>RANOMASTOWN</u>		10d. Inside City Limits		
10e. Street and Number <u>4004 Dorchester Road</u>				10f. Zip Code <u>21207</u>		10g. Citizen of What Country? <u>U.S.A</u>		
11. Marital Status <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <u>1</u> Yes <u>2</u> No		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
15. Decedent's Education (Specify only highest grade completed) <u>11</u> Elementary/Secondary (0-12) <u>College (1-4 or 5+)</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Laborer</u>		16b. Kind of Business/Industry <u>None</u>		
17. Father's Name (First, Middle, Last) <u>George Mitchell</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Blanche Way</u>				
19a. Informant's Name/Relationship (Type, Print) <u>George B. Mitchell (Brother)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4004 Dorchester Rd. Baltimore, Md. 21207</u>				
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Springhill Mem. Garden</u>		20c. Date <u>9/26/00</u>		20d. Location - City or Town, State <u>Hebron, Md.</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Stewart Funeral Home</u> <u>821 West Rd. Salisbury, Md. 21801</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): <u>b. DIABETES</u> Due to (or as a consequence of): <u>c. HYPERTENSION</u> Due to (or as a consequence of): <u>d.</u>		Approximate Interval Between Onset and Death <u>YES</u> <u>YES</u> <u>YES</u>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA</u>				23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown				
24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No				24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No				
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)						
27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>3</u> Accident <u>6</u> Could not be determined <u>4</u> Suicide <u>2</u> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>1120333</u>		29d. Date signed (Month, Day, Year) <u>9/26/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>K. ZANES MD</u> <u>1838 GREENIDGE RD</u> <u>PRESVILLE MD</u>								31. Date filed (Month, Day, Year) <u>SEP 27 2000</u>
32. Registrar's Signature <u>[Signature]</u>								33. Date <u>2/28</u>

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32286

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Theresa Turner Neal				2. Date of Death Month Sept. Day 19 Year 2000		3. Time of Death 7:05 am	
	4a. Facility Name (If not Institution, give street and number) Mariner Health C Circle Manor				4b. City, Town, or Location of Death Kensington		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 409-20-3792		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 25, 1921	9. Birthplace (State or Foreign Country) Norwood, Ga.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Montgomery		10c. City, Town or Location Kensington			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 10231 Carroll Place				10f. Zip Code 20895		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Gov. Dept. of Army	
	17. Father's Name (First, Middle, Last) Robert Turner				18. Mother's Name (First, Middle, Maiden Surname) Etheline Hill			
	19a. Informant's Name/Relationship (Type, Print) Bessie Moore Cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 980 Azalea Drive Roswell, Ga. 30075			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverdale Park Crematory		Date 9/25/00		20c. Location - City or Town, State Riverdale, Md.	
	21. Signature of Funeral Service Licensee Francis B. Hunt				22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St. N.W. Wash. D.C. 20011			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Myron L. Lenkin M.D.		29c. License number DO6674		29d. Date signed (Month, Day, Year) Sept. 22, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myron L. Lenkin, M.D. 2309 Shorefield Rd. Silver Spring, Md. 20902								
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature Francis B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32287

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Charles Christopher Nagy

2. Date of Death

Month Day Year
SEPTEMBER 22, 2000

3. Time of Death

9:15 P.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

AAFB
CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

301-56-1848

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 27, 1956

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Springfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6976 Conservation Drive

10f. Zip Code

22153-1013

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1974-1981

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

1 College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Corp. Security

17. Father's Name (First, Middle, Last)

Charles Terry Nagy

18. Mother's Name (First, Middle, Maiden Summa)

Catherine Ann Rubin

19a. Informant's Name/Relationship (Type, Print)

Katherine Nagy (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6976 Conservation Drive Springfield VA 22153-1013

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

Sept. 24, 2000

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

▶ *[Signature]*

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Road

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

UNKNOWN

b. RENAL FAILURE

Due to (or as a consequence of):

5 DAYS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. METASTATIC CANCER

Due to (or as a consequence of):

UNKNOWN

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *[Signature]*

29c. License number

PA MD069539L

29d. Date signed (Month, Day, Year)

SEPTEMBER 22, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SCOTT REHRIG, CAPT, USAF, MC

89 MDG/1050 W. PERIMETER RD.

ANDREWS AIR FORCE BASE, MD 20762-6600

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

▶ *[Signature]*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

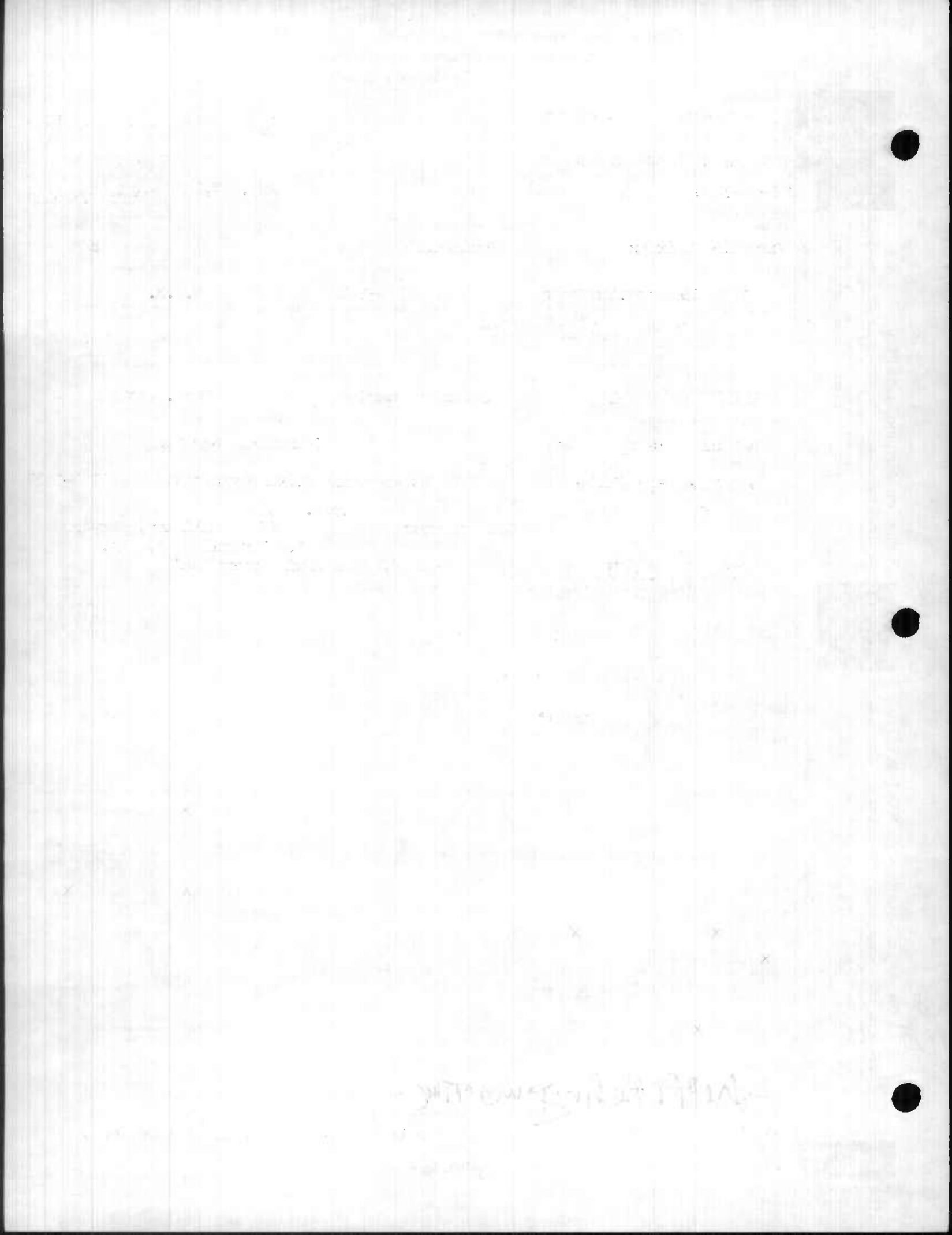
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32288

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ann Neal

2. Date of Death

Month Day Year
Sept. 17, 2000

3. Time of Death

10:20 am

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

579-84-2917

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 6, 1959

9. Birthplace (State or Foreign Country)

Wash.D.C

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

21006 Sojourn Court

10f. Zip Code

20876

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Health Care Marketing

16b. Kind of Business/Industry

Health Care
Management

17. Father's Name (First, Middle, Last)

Roslyn Neal

18. Mother's Name (First, Middle, Maiden Surname)

Theresa Turner

19a. Informant's Name/Relationship (Type, Print)

Ruby Parrish Sherman Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1674 Tamarack St.N.W.Wash.D.C.20012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

Date

9/25/00

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

Francis B. Hunt

22. Name and Address of Facility

Hunt Funeral Home
908 Kennedy St.N.W.Wash.D.C.2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. PULMONARY EMBOLUS

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CROHN'S DISEASE

PERIRECTAL ABSCESS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Alan Diamond, MD

29c. License number

D24245

29d. Date signed (Month, Day, Year)

9/19/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ALAN DIAMOND, MD. 10 FOICOCKWOOD DRIVE; SILVER SPRING, MD 20901

State
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32289

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JACK NELSON		2. Date of Death Month SEP Day 23 Year 2000		3. Time of Death 2143
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 178-30-5313	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
	8. Date of Birth (Month, Day, Year) AUGUST 1, 1936		9. Birthplace (State or Foreign Country) IOWA		
Usual Residence of Decedent					
10a. State MD		10b. County WORCESTER		10c. City, Town or Location SHOWELL	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 11629 CHURCH ST.			10f. Zip Code 21862		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALESMAN		16b. Kind of Business/Industry HARDWARE	
17. Father's Name (First, Middle, Last) HOLGAR NELSON			18. Mother's Name (First, Middle, Maiden Surname) LOUISE (UNKNOWN)		
19e. Informant's Name/Relationship (Type, Print) LAURA A. NELSON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 44, SHOWELL, MD 21862		
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CREMATORY OF DELMARVA		20c. Location - City or Town, State 9/24/00 DELMAR, DE	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE			
23a. Pert - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. cardiopulmonary arrest Due to (or as a consequence of): b. cerebrovascular accident Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier  MD		29c. License number D54807		29d. Date signed (Month, Day, Year) 09-24-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Agarwal, M.D. 1315 South Division St. Salisbury md. 21804					
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 			
State Registrar					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32290

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANTHONY OWENS				2. Date of Death Month Day Year SEPT. 18, 2000		3. Time of Death 0147 AM	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 577-96-7632	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 30	8. Date of Birth (Month, Day, Year) June 21, 1970	9. Birthplace (State or Foreign Country) Washington, D.C.			
	Usual Residence of Decedent							
10a. State DC.		10b. County Washington,		10c. City, Town or Location Washington,		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 918 45th Place, N.E.				10f. Zip Code 20019		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpet Technician		16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Jerry Coppock				18. Mother's Name (First, Middle, Maiden Surname) Mary Owens				
19a. Informant's Name/Relationship (Type, Print) Eugenia Denise Owens/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9401 Silverfox Turn, Clinton, Maryland 20736				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Date 9/23/00		20d. Location - City or Town, State Landover, Maryland		
21. Signature of Funeral Service Licensee Alex S. Pope Jr.				22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SEDC 20020				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 9/17/00		28b. Time of Injury 2350 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred Pedestrian struck By Motor Vehicle		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 295 Cheverly, Maryland				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier J. Pestaner, M.D.				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPT. 18, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32291

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward J O'Connell				2. Date of Death Month SEP Day 25 Year 2000		3. Time of Death 10 05 AM		
	4a. Facility Name (If not institution, give street and number) Howard County General Hospital				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard		
Funeral Director	5. Social Security Number 021-24-4173		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67		8. Date of Birth (Month, Day, Year) June 11, 1933		
	9. Birthplace (State or Foreign Country) Massachusetts		10a. State MD		10b. County Howard		10c. City, Town or Location Sykesville		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12643 Howard Lodge Drive		10f. Zip Code 21784		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer		16b. Kind of Business/Industry Engineering		17. Father's Name (First, Middle, Last) Edward David O'Connell		18. Mother's Name (First, Middle, Maiden Surname) Marie Beatrice Perron	
19a. Informant's Name/Relationship (Type, Print) Mrs. Joenne M. O'Connell (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12643 Howard Lodge Drive Sykesville, MD 21784		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All County Cremation Srv.		20c. Location - City or Town, State 9/29/00 Sykesville, MD	
21. Signature of Funeral Service Licensee ► Paige Staight Herbert		22. Name and Address of Facility Haight Funeral Home & Chapel PA (Box 195) Sykesville, MD 21784 (410)-795-1400		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction		Approximate Interval Between Onset and Death Hours			
Immediate Cause (Final disease or condition resulting in death)		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sleep Apnea Renal Insufficiency Ischemic Cardiomyopathy		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury 1 11 Yes 2 No	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier ► Michael E. Silverman MD		29c. License number 041274		29d. Date signed (Month, Day, Year) SEP 25, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael E. Silverman, MD Howard Co Gen Hosp Columbia, MD 21044		31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature ► [Signature]					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32292

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Troy H. Pearson			2. Date of Death Month Day Year September 17, 2000		3. Time of Death 9:45pm	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital			4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 247-20-5551		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) April 6, 1915
	9. Birthplace (State or Foreign Country) Summerton, S.C.		10a. State D.C.		10b. County Washington		10c. City, Town or Location Washington
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 333-34th Street N.E.		10f. Zip Code 20019		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Washington Gas Pipeman		16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Gussie Pearson			18. Mother's Name (First, Middle, Maiden Surname) Fannie Brunson				
19a. Informant's Name/Relationship (Type, Print) Doris M. Pearson / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333-34th Street N.E. Washington, D.C. 20019				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 9/25/2000		20c. Location - City or Town, State Brentwood, Md.	
21. Signature of Funeral Service Licensee <i>Keith A. Savage MD</i>			22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>Diabetic ketoacidosis</i> b. c. d. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Onset and Death <i>hours-days</i>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Leisa M.D.</i>			29c. License number D 53411		29d. Date signed (Month, Day, Year) September 18th 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JC Shesadi 3060 Mitchellville Rd #103 Bowie MD 20716							
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature <i>B. Jones</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32293

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Christos C. Poppo		2. Date of Death Month Day Year Sept. 21, 2000		3. Time of Death 7:15 am	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital		4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 220-28-7438	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 26, 1933
	9. Birthplace (State or Foreign Country) Greece					
Usual Residence of Decedent						
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2111 Guilford Road #303			10f. Zip Code 20783		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1/23/57 3/31/61		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security		16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) Constantinos Poppo			18. Mother's Name (First, Middle, Maiden Surname) Angeliky Scouperas			
19a. Informant's Name/Relationship (Type, Print) Harry Poppo - Brother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2021 Reddie Drive, Silver Spring, MD 20902			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD Veteran's Cemetery		20c. Location - City or Town, State 9/27/00 Cheltenham, MD		
21. Signature of Funeral Service Licensee Wm. R. Smith			22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. CARDIORESPIRATORY ARREST Due to (or as a consequence of):</p> <p>b. RESPIRATORY FAILURE Due to (or as a consequence of):</p> <p>c. PNEUMONIA Due to (or as a consequence of):</p> <p>d. SEIZURE DISORDER</p> </div> </div>						
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Wm. R. Smith MD			29c. License number D46529		29d. Date signed (Month, Day, Year) 9/22/2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VICTOR ONYESIATA 7325A HARPOVER PARKWAY GREENBELT MARYLAND						
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature B. Sparks				

THE STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901.
REPORT OF THE
COMMISSIONER OF THE LAND OFFICE.

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1901.

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State of Maryland / Department of Health and Mental Hygiene

00 32294

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alice Winifred Pool</i>				2. Date of Death Month: <i>Sept</i> Day: <i>25</i> Year: <i>2000</i>		3. Time of Death <i>2:35 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>				4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>219-22-7090</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>75</i> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <i>6/6/1925</i>		9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent							
10a. State <i>MD.</i>		10b. County <i>PRINCE GEORGE'S</i>		10c. City, Town or Location <i>BELTSVILLE</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>11615 34th PLACE</i>				10f. Zip Code <i>20705</i>		10g. Citizen of What Country? <i>USA.</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+) <i>4</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>TEACHER</i>			16b. Kind of Business/Industry <i>EDUCATION</i>	
17. Father's Name (First, Middle, Last) <i>JARRETT W. SHAUCK</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ALICE ARNOLD</i>				
19a. Informant's Name/Relationship (Type, Print) <i>EASTON POOL -HUSBAND</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11615 34th PLACE, BELTSVILLE, MD. 20705</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>LAKE VIEW MEM. PARK</i>		Date <i>9/28/00</i>		20c. Location - City or Town, State <i>ELDERSBURG, MD.</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Respiratory failure</i> Due to (or as a consequence of): b. <i>Metastatic lung carcinoma</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death <i>weeks</i> <i>weeks</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aspiration pneumonia, Parkinson's disease, Depression</i>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>[Signature] MD, FCCP</i>				29c. License number <i>D 36845</i>		29d. Date signed (Month, Day, Year) <i>Sept 25, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Mar-Chi Nguyen, MD, FCCP 7350 Grace Drive, Columbia, MD 21044</i>								
State Registrar		31. Date filed (Month, Day, Year) <i>SEP 28 2000</i>		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32295

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hazel M. Penix				2. Date of Death Month Day Year Sept. 27 2000				3. Time of Death 2:30 AM				
	4a. Facility Name (If not institution, give street and number) 4650 Roop Road				4b. City, Town, or Location of Death Mt. Airy				4c. County of Death Carroll				
Funeral Director	5. Social Security Number 293-28-2671		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Nov. 9, 1923		9. Birthplace (State or Foreign Country) Kentucky		
	Usual Residence of Decedent				10a. State Maryland				10b. County Carroll		10c. City, Town or Location Mt. Airy		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 4650 Roop Road				10f. Zip Code 21771				10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner				16b. Kind of Business/Industry Service Station/Garage					
17. Father's Name (First, Middle, Last) John A. Conley				18. Mother's Name (First, Middle, Maiden Surname) Hattie Cantrell									
19a. Informant's Name/Relationship (Type, Print) W. Gail Kline daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4650 Roop Road Mt. Airy, MD 21771									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hanover Cemetery				Data 9/30/2000		20c. Location - City or Town, State Hanover, Ohio			
21. Signature of Funeral Service Licensee James B. Conway				22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Sykesville, MD 21784									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bowel ischemia Due to (or as a consequence of): b. Abdominal Aortic Aneurysm Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 week 4 year..					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End stage Renal disease										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier M. Nasir MD				29c. License number D35711		29d. Date signed (Month, Day, Year) 9/27/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mokhtar Nasir, 904 Washington Rd, suite D Westminster, MD 21157.													
31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature [Signature]									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

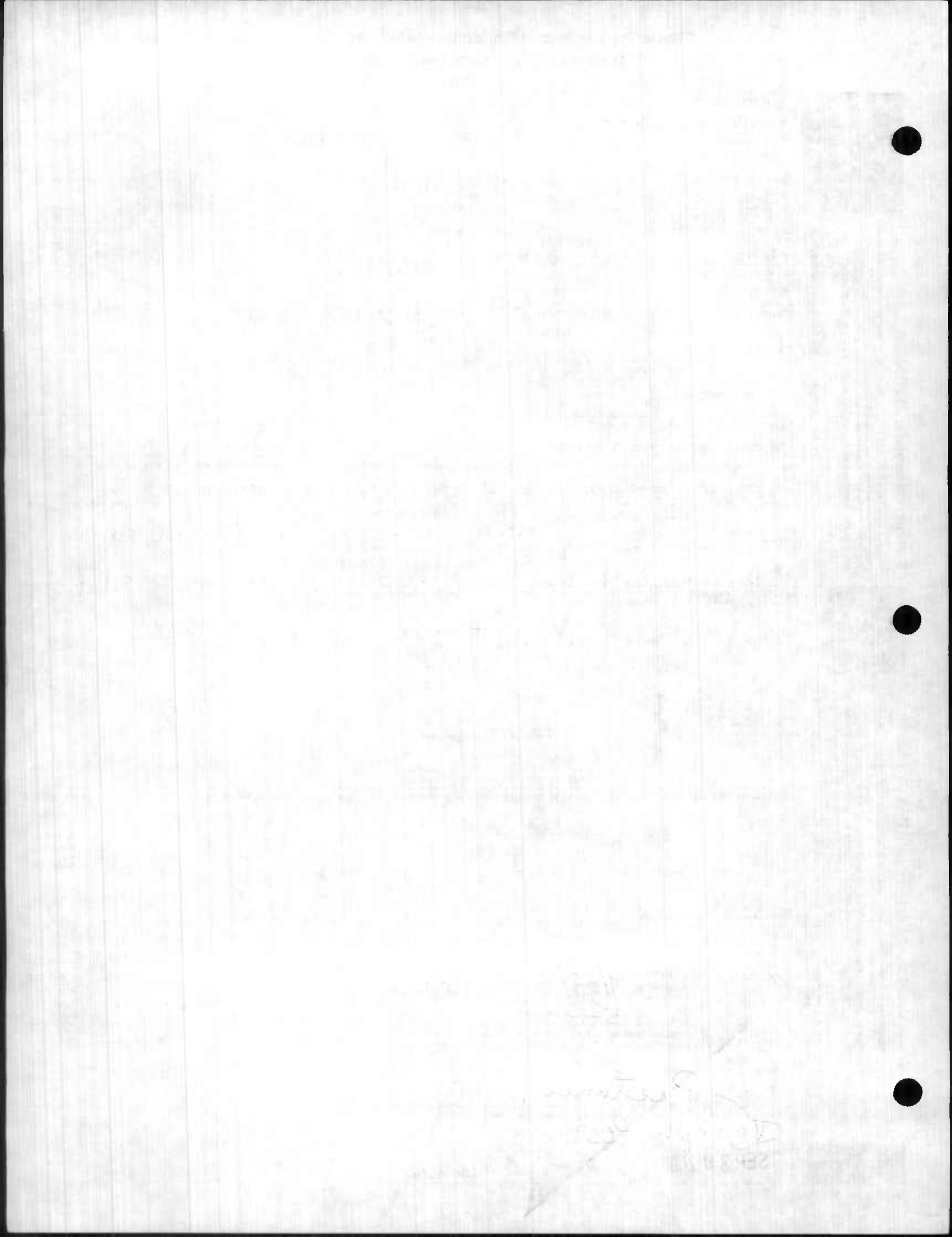
State of Maryland / Department of Health and Mental Hygiene 00 32296

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ricardo Montesinos Perez		2. Date of Death Month Day Year SEPTEMBER 26, 2000		3. Time of Death 12:05 A.M.
	4a. Facility Name (If not institution, give street and number) ROUTE 155 and WEBSTER LAPIDERM ROAD		4b. City, Town, or Location of Death HAVRE de GRACE		4c. County of Death HARFORD
Funeral Director	5. Social Security Number 223-89-0132	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 19 Yrs.	8. Date of Birth (Month, Day, Year) DEC 18, 1981	9. Birthplace (State or Foreign Country) Mexico
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Delaware	10b. County New Castle	10c. City, Town or Location Newark		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 55 Egret Court		10f. Zip Code 19702		10g. Citizen of What Country? Mexico
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Mexican
	14. Race - American Indian, Black, White, etc. Specify: Hispanic		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Kind of Business/Industry Maintenance
	17. Father's Name (First, Middle, Last) Reynaldo Montesinos Salcedo		18. Mother's Name (First, Middle, Maiden Surname) Eulalia Perez Perez		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Roberto Montesinos Perez/Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Egret Court, Newark, Delaware 19702		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R.A. Ferris & Co., Inc.		20c. Location - City or Town, State 10/2/00 West Chester, PA
	21. Signature of Funeral Service Licensee Donald S. Hicks		22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Injuries		Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 9/25/00 28b. Time of Injury 11:03 PM 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 28d. Describe how injury occurred Passenger of Motor vehicle collides with another vehicle 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rte 155 Harford County, Md			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Joseph Pestaner, M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) SEPTEMBER 26, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature B. Sparks			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32297

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES HOOPER PARROTT						2. Date of Death Month Day Year SEPT. 23 2000		3. Time of Death 4:30 PM	
	4a. Facility Name (If not institution, give street and number) 515 PARK AVENUE						4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 163-16-5344		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 7, 1915		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 515 PARK AVENUE				10f. Zip Code 21801		10g. Citizen of What Country? U. S. A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OWNER/ OPERATOR			16b. Kind of Business/Industry SALVAGE		
	17. Father's Name (First, Middle, Last) HARVEY MADISON PARROTT						18. Mother's Name (First, Middle, Maiden Surname) MABLE HOOPER			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SHIRLEY PARROTT - WIFE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 PARK AVE. SALISBURY, MARYLAND 21801			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY		Date 9/25/00		20c. Location - City or Town, State CAMBRIDGE, MARYLAND			
	21. Signature of Funeral Service Licensee B. Kestel				22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. congestive cardiomyopathy Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown Approximate Interval Between Onset and Death 5 years									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Charles B. Silva Jr MD						29c. License number D30853		29d. Date signed (Month, Day, Year) 9/25/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B. Silva Jr MD 100 Power Street Salisbury MD 21804										
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32298

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS GLORIA ROBERSON

2. Date of Death

September 23, 2000

3. Time of Death

10:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

7748 Bender Road

4b. City, Town, or Location of Death

Landover

4c. County of Death

Prince George's

5. Social Security Number

578-52-9716

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 12, 1941

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7748 Bender Road

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Winon Jones

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Wran

19a. Informant's Name/Relationship (Type, Print)

Daniel Roberson/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7748 Bender Road, Landover, Maryland 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

09/29
2000

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perantoni

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Colon Cancer

Approximate
Interval Between
Onset and Death

10 Months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30666

29d. Date signed (Month, Day, Year)

September 26, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Badeau, M.D., 1450 Merchantile Lane, #217, Largo, Maryland

State
Registrar

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

22



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32299

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TERRY KENNEDY RYALS

2. Date of Death

September 24, 2000

3. Time of Death

1945

4a. Facility Name (If not Institution, give street and number)

6411 Lamont Drive

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

579-06-2525

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 5, 1968

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6411 Lamont Drive

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Counselor

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Ryals

18. Mother's Name (First, Middle, Maiden Surname)

Emily J. Wallace

19a. Informant's Name/Relationship (Type, Print)

Emily J. Cash/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6411 Lamont Drive, Hyattsville, Maryland 20784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Ceme.

Date

10/03

2000

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Pascenti

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Salvador Sylvestre, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvestre, 3001 Hospital Drive, Cheltenham, Maryland 20785

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32300

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carl Stansbury Ridgeley

2. Date of Death

Month Day Year
SEPTEMBER 24, 2000

3. Time of Death

2:45 PM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral
Director

5. Social Security Number

219-01-1461

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 13, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Port Deposit

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 Green Lane

10f. Zip Code

21904

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Six Years

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurses Aid

16b. Kind of Business/Industry

V.A. Medical Center

Perry Point, Maryland

17. Father's Name (First, Middle, Last)

Robert Ridgeley

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Stansbury

19a. Informant's Name/Relationship (Type, Print)

Bertha I. Jackson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

79 Cokesbury Road, Port Deposit, Maryland 21904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Berkley Cemetery

Date

9/28/00

20c. Location - City or Town, State

Darlington, Maryland

21. Signature of Funeral Service Licensee

Thomas M. Patterson, Sr.

22. Name and Address of Facility

Lee A. Patterson & Son Funeral Home, P.A.

Perryville, Maryland 21903-0766

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEVERE BACTERIAL PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEVERE SEPSIS

Due to (or as a consequence of):

UNKNOWN

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

S. Sodhi

29c. License number

D42014

29d. Date signed (Month, Day, Year)

SEPTEMBER 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State
Registrar

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

S. Sodhi

NAME KNOWN TO PHYSICIAN:
CHARLES RIDGLEY

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32301

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Lois C. Rollins</u>				2. Date of Death Month <u>October</u> Day <u>01</u> Year <u>2000</u>		3. Time of Death <u>0945</u>													
	4a. Facility Name (If not Institution, give street and number) <u>UNION HOSPITAL</u>				4b. City, Town, or Location of Death <u>ELKTON</u>		4c. County of Death <u>CECIL</u>													
Funeral Director	5. Social Security Number <u>216-30-5282</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>67</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>SEPTEMBER 12, 1933</u>	9. Birthplace (State or Foreign Country) <u>COCKEYSVILLE, MD.</u>												
	Usual Residence of Decedent				10a. State <u>MARYLAND</u>		10b. County <u>CECIL</u>													
To Be Completed by Funeral Director	10c. City, Town or Location <u>ELKTON</u>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>#4 WINDING WAY</u>													
	10f. Zip Code <u>21921</u>				10g. Citizen of What Country? <u>USA</u>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>3</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>REGISTERED NURSE</u>		16b. Kind of Business/Industry <u>HEALTH CARE</u>													
	17. Father's Name (First, Middle, Last) <u>WILLIAM K. LEE, JR.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>VIOLET JOHNSTON</u>															
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>HUSBAND</u> <u>JUDGE EDWARD D. C. ROLLINS, JR.</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>#4 WINDING WAY ELKTON, MD 21921</u>															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>IMMACULATE CONCEPTION R.C. CEMETERY</u>		20c. Location - City or Town, State <u>10/4/00 CHERLY HILL, MARYLAND</u>													
	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>GEE FUNERAL HOME</u> <u>259 E. MAIN ST. ELKTON, MD 21921</u>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><u>Pulmonary Hypertension</u></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><u>Cor pulmonale</u></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td><u>COPD</u></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<u>Pulmonary Hypertension</u>	Due to (or as a consequence of):	b.	<u>Cor pulmonale</u>	Due to (or as a consequence of):	c.	<u>COPD</u>	Due to (or as a consequence of):	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<u>Pulmonary Hypertension</u>	Due to (or as a consequence of):																	
	b.	<u>Cor pulmonale</u>	Due to (or as a consequence of):																	
	c.	<u>COPD</u>	Due to (or as a consequence of):																	
	d.		Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M														
				28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred														
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier <u>William Covell</u>				29c. License number <u>DO054584</u>		29d. Date signed (Month, Day, Year) <u>10/1/00</u>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>William Covell 817 N. BROAD STREET Middletown, DE 19709</u>																				
31. Date filed (Month, Day, Year) <u>OCT 03 2000</u>				32. Registrar's Signature <u>[Signature]</u>																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32302

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILTON THOMAS RUARK				2. Date of Death Month: SEPT. Day: 25, Year: 2000				3. Time of Death 0046 AM	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 216-40-3422		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 3, 1943		9. Birthplace (State or Foreign Country) DELAWARE	
	Usual Residence of Decedent				10c. City, Town or Location SALISBURY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. State MARYLAND		10b. County WICOMICO		10f. Zip Code 21804				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: AIR FORCE		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WELDER				16b. Kind of Business/Industry ELECTRIC POWER CO.		
17. Father's Name (First, Middle, Last) MILTON A RUARK				18. Mother's Name (First, Middle, Maiden Surname) VIRGINIA E. HUDSON						
19a. Informant's Name/Relationship (Type, Print) SANDRA R. HALL - SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29246 HALLWOOD RD HALLWOOD, VA 23359						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) PITTSVILLE CEMETERY		20c. Location - City or Town, State PITTSVILLE, MARYLAND				
21. Signature of Funeral Service Licensee B. Keister P. Hyman CFSP				22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 9-24-00		28b. Time of Injury 2:30 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred motor vehicle collision
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street				28b. Location (Street and Number or Rural Route Number, City or Town, State) Salisbury, Md						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dennis J. Chuteno				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPT. 25, 2000
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chuteno				31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature B. Sparks		

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 32303

Certificate of Death

Reg. No.

REPLACEMENT

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Russell Nathaniel Roberts				2. Date of Death Month Day Year August 18 2000				3. Time of Death 0937	
	4a. Facility Name (If not Institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot	
Funeral Director	5. Social Security Number 214-12-5496		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) June 15, 1922		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD		10b. County Talbot		10c. City, Town or Location Trappe	
To Be Completed by Funeral Director	10e. Street and Number 4070 Hennissee Lane				10f. Zip Code 21673		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Care Taker				16b. Kind of Business/Industry Self Employed	
	17. Father's Name (First, Middle, Last) Charles Roberts				18. Mother's Name (First, Middle, Maiden Surname) Ida Blake					
	19a. Informant's Name/Relationship (Type, Print) Marjorie Roberts				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4070 Hennissee Lane Trappe, MD 21673					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Paradise Cemetery		20c. Location - City or Town, State Trappe, Maryland		20d. Date 8/22/00	
	21. Signature of Funeral Service Licensee Janelle C. Henry, Per DVR				22. Name and Address of Facility Henry Funeral Home, P.A., 510 Washington St. Cambridge, MD 21613					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				Approximate Interval Between Onset and Death 30 minutes	
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE DIABETES MELLITUS TYPE 1				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Michael A. Moskewicz MD				29c. License number D-16609		
29d. Date signed (Month, Day, Year) August 18, 2000				30. Name and address of person who completed cause of death (Type, Print) MICHAEL A. MOSKEWICZ MD 503 BYRD ST CAMBRIDGE MD 21613						
31. Date filed (Month, Day, Year) OCT 11 2000				32. Registrar's Signature Benjamin B. Sparks						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

00 32304

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET LOANE SUTHERLAND				2. Date of Death Month Day Year September 16, 2000		3. Time of Death 5:20 PM	
	4a. Facility Name (If not institution, give street and number) 4950 Allan Road				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 578-40-4054	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 26, 1906		9. Birthplace (State or Foreign Country) Washington, D.C.
	Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 4950 Allan Road				10f. Zip Code 20816		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry D.C. Public School System	
17. Father's Name (First, Middle, Last) John T. Stansbury Loane				18. Mother's Name (First, Middle, Maiden Surname) Georgianna Elvans Alarcomb				
19a. Informant's Name/Relationship (Type, Print) Sandra Woodall/friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4950 Allan Road, Bethesda, MD 20816				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Data 09/27/2000		20c. Location - City or Town, State Suitland, MD
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Dementia Due to (or as a consequence of): b. Severe Obstructive Lung Disease Due to (or as a consequence of): c. Aspiration pneumonia Due to (or as a consequence of): d. Decubiti Ulceration								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number MD 056065		29d. Date signed (Month, Day, Year) 9/18/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlos E. Picone, M.D. 5454 Wisconsin Ave. #1125 Chevy Chase, MD 20815								
31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #17, P.G. G.C. 9/28/00

Certificate of Death

Reg. No.

00 32305

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Franklin E. Smith

2. Date of Death

Month Day Year
Sept. 12, 2000

3. Time of Death

16:21

4a. Facility Name (If not institution, give street and number)

Prince Georges Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

P.G.

Funeral
Director

5. Social Security Number

239 14 7172

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 13, 1921

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4272 East Capitol St., N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Fed. Govt.

17. Father's Name (First, Middle, Last)

Jimmy Stevens Edward M. Smith

18. Mother's Name (First, Middle, Maiden Summa)

Mattie Morehead

19a. Informant's Name/Relationship (Type, Print)

Ernestine Tranquille / Dau.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

446B Chester St. Apt B Brooklyn NY 11212

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

QUANTICO NATIONAL

Date

9/22/00

20c. Location - City or Town, State

TRIANGLE, VA

21. Signature of Funeral Service Licensee

[Signature] CC0273

22. Name and Address of Facility

John T. Rhines Co.

3030 12th St., N.E. Wash., D.C. 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Immediate Cause (Final
disease or condition
resulting in death)Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

[Signature] Salvador S. Aponte, DO

29c. License number

140255927

29d. Date signed (Month, Day, Year)

September 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Aponte, 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

[Signature] B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32306

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Steve A. Surtees

2. Date of Death

Month Day Year
September 25, 2000

3. Time of Death

10:10PM

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

5. Social Security Number

216-38-6820

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 16, 1937

9. Birthplace (State or Foreign Country)

Hungary

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9225 Allentown Road

10f. Zip Code

20744

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1958-1964

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Locksmith

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Ferenc Toth

18. Mother's Name (First, Middle, Maiden Surname)

Emilia Gadjos

19a. Informant's Name/Relationship (Type, Print)

Blanca Surtees/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery 10/3/2000 Cheltenham, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Metastatic liver cancer

Approximate Interval Between Onset and Death

6 m.

Due to (or as a consequence of):

Hepatic Encephalopathy

2 d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45365

29d. Date signed (Month, Day, Year)

9-26-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Sidorous, 11701 Livingston Rd A12, Ft Washington MD 20748

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

[The body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table, but the specific content cannot be discerned.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32307

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rosa Lee Shaffer

2. Date of Death

September 21, 2000 10:35PM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Doctors Hospital, Lanham

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

310-32-8249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 7, 1933

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Lanham

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9407 Fontana Drive

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Fred Clatterbuck

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Wood

19a. Informant's Name/Relationship (Type, Print)

Deborah Shaffer (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9407 Fontana Drive Lanham, Maryland 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sept. 27, 2000
Maryland State Veterans Cem.

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Kelli R. Patter

22. Name and Address of Facility

Lee Funeral Home, Inc.
6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 Hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

N/A

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael Berand, MD

29c. License number

D26287

29d. Date signed (Month, Day, Year)

9/23/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Michael BERAND 7305 Balt Ave 107 College Park MD 20740

State
Registrar

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Rosa Shaffer
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32308

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACK RAY SAMPLE

2. Date of Death

September 21, 2000

3. Time of Death

0730

4a. Facility Name (If not institution, give street and number)

16005 Marlboro Pike

4b. City, Town, or Location of Death

Upper Marlboro Prince Georges

4c. County of Death

9. Birthplace (State or Foreign Country)

MONTANA

5. Social Security Number

240-84-3037

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

04/04/1948

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

16005 MARLBORO PIKE

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PURCHASING AGENT

16b. Kind of Business/Industry

BUILDING SUPPLY

17. Father's Name (First, Middle, Last)

ALEXANDER SAMPLE

18. Mother's Name (First, Middle, Maiden Summa)

BETTY BAKER

19a. Informant's Name/Relationship (Type, Print)

ROBERT SAMPLE/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2702 KIRK LN. BOWIE, MD. 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. VET. CEMETERY

Date

9/26/2000 CHELTENHAM, MD.

21. Signature of Funeral Service Licensee

KYLE SIMONS M01206

22. Name and Address of Facility

BEALL FUNERAL HOME

6512 N.W. CRAIN HWY. BOWIE, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Self-inflicted Gunshot wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

September 21, 2000

28b. Time of Injury

7:30 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred Self-inflicted gunshot wound to head

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

16005 Marlboro Pike, Upper Marlboro, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador Siverio, MD

29c. License number

H2055927

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Siverio, 3001 Hospital Drive, Cheverly, Maryland 20715

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Spinks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, mostly illegible due to fading. Some words like "The" and "and" are visible.

Handwritten text, possibly a signature or a specific heading.

Handwritten text at the bottom of the page, including what appears to be a date and some descriptive notes.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32309

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACQUELINE R. SIMMONS

2. Date of Death
Month Day Year

September 24 2000

3. Time of Death

16/0

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2728 Lorrington Drive

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince George's

5. Social Security Number

238-96-6010

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 10, 1953

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2728 Lorrington Drive, #204

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Willie Lee Haskins

18. Mother's Name (First, Middle, Maiden Surname)

Lula Russell

19a. Informant's Name/Relationship (Type, Print)

Kevin Haskins/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2728 Lorrington Dr., #204, Forestville, MD 20747

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Church Cemetery

Data

09/30

2000

20c. Location - City or Town, State

Manson, N.C.

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Salvador S. S. S.

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

September 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. S. S. 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. S. S.

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-1000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32310

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary L. Sansbury				2. Date of Death Month Day Year September 24, 2000		3. Time of Death 9:40PM	
	4a. Facility Name (If not institution, give street and number) 3904 Canterbury Way				4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577-36-7825	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 72	8. Data of Birth (Month, Day, Year) Sept. 13, 1928	9. Birthplace (State or Foreign Country) Washington, DC			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Temple Hills			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10a. Street and Number 3904 Canterbury Way				10f. Zip Code 20748		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teller		16b. Kind of Business/Industry Banking		
	17. Father's Name (First, Middle, Last) Pasquale A. Maggio				18. Mother's Name (First, Middle, Maiden Surname) Mary M. Kines			
	19a. Informant's Name/Relationship (Type, Print) Mary K. Brotherton/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4107 Riverview Ct. Dunkirk, Md. 20754			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Washington Nat. Cem.		20c. Location - City or Town, State Suitland, Md.		
	21. Signature of Funeral Service Licensee George P. Kalas			22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medical Certification: To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Bruce A. Silver, MD				29c. License number 021463		29d. Date signed (Month, Day, Year) 9-25-2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUCE A. SILVER, MD 110 HOSPITAL RD, PRINCE FREDERICK, MD 20678							
State Registrar	31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature B. Sparks					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32311

amend item 23a, 27, G788 10/16/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harvey Tyrone Shivers, Jr.				2. Date of Death Month Day Year SEPTEMBER 27, 2000				3. Time of Death 14:40 PM		
	4a. Facility Name (If not institution, give street and number) 615 63rd PLACE				4b. City, Town, or Location of Death SEAT PLEASANT				4c. County of Death PRINCE GEORGE'S		
Funeral Director	5. Social Security Number 579-90-5393		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 18, 1959		9. Birthplace (State or Foreign Country) Rockville, Md.		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Seat Pleasant				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 615 63rd Place				10f. Zip Code 20743				10g. Citizen of What Country? United States			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaper				16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Harvey Shivers				18. Mother's Name (First, Middle, Maiden Surname) Gladys Feldor							
19a. Informant's Name/Relationship (Type, Print) Harvey Shivers/ Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 63rd Place Seat Pleasant, Md. 20743							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem.		Date 10/6/00		20c. Location - City or Town, State Beltsville Md.			
21. Signature of Funeral Service Licensee Keith A. Savage M01085				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier J. M. Titus				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) SEPTEMBER 28, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32312

amend item 23a,27, per me G788 10/16/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruby Smith				2. Date of Death Month Day Year OCTOBER 04, 2000		3. Time of Death 12:35 A.M.	
	4a. Facility Name (If not institution, give street and number) 14800 4th STREET APARIMENT 84D				4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 247-02-7124		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) July 1, 1952	
	9. Birthplace (State or Foreign Country) Sumter, S.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 14800 4th St.		10f. Zip Code 20708		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled		16b. Kind of Business/Industry N/A			
	17. Father's Name (First, Middle, Last) James Mayrmant				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Mayrant			
	19a. Informant's Name/Relationship (Type, Print) Dontez Smith / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 #C Mountain Ridge CT. Glen Burnie, Md.			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 10/10/00		20c. Location - City or Town, State Landover, Md.	
	21. Signature of Funeral Service Licensee <i>Kutha A. [Signature]</i>		22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md.		20747			
	23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. SEIZURE DISORDER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Dennis J. Chuteau</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 04, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 05 2000		32. Registrar's Signature <i>B. Sparks</i>						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32313

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY D. SMITH

2. Date of Death

Month Day Year
SEPTEMBER 22, 2000

3. Time of Death

12:45pm
12:39pm

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

235-12-1838

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
Aug 5, 1920

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Eldersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1663 Gemini Drive

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Clarence John Davis

18. Mother's Name (First, Middle, Maiden Surname)

Beatrice Mahoney

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary S. Cremen (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6827 Ridge Road Eldersburg, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

9/26/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Brian A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Biliary Sepsis
Due to (or as a consequence of):

2 weeks

c. Hemorrhagic pancreatitis
Due to (or as a consequence of):

2 weeks

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Matilda H. So, MD

29c. License number

D 26250

29d. Date signed (Month, Day, Year)

September 22, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MATILDA H. SO, 6701 NORTH CHARLES ST, BALTO, MD 21204

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

Beverly B Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Smith, Mary

9/22/2000

12:45pm

00 32314

ORIGINAL

1000

1000

1000

1000

1000

1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32315

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Alvin Super				2. Date of Death Month Day Year Sept. 27, 2000				3. Time of Death 1:03 Am	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll County	
Funeral Director	5. Social Security Number 215-01-4750		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) 83 Yrs.		8. Date of Birth Month Day Year Apr. 10, 1917		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll County		10c. City, Town or Location Sykesville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10a. Street and Number 922 Buckhorn Road				10f. Zip Code 21784		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Newspaper Pressman			16b. Kind of Business/Industry Printing		
	17. Father's Name (First, Middle, Last) George Alvin Super				18. Mother's Name (First, Middle, Maiden Surname) Ellen Virginia Hurley					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Dorothy M. Super (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 922 Buckhorn Road Sykesville, MD 21784					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn Memorial Gardens				20c. Date 09/30/00		20d. Location - City or Town, State Marriottsville, MD	
	21. Signature of Funeral Service Licensee Brian A. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC PROSTATE CANCER Due to (or as a consequence of): b. ANEMIA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death > 1 YEAR > 3 MONTHS									
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Patrick A. Turner		29c. License number D 20806		29d. Date signed (Month, Day, Year) September 27 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICK A. TURNER, MD SUITE 102, 1000 LIBERTY RD ELDERSBURG MD 21784									
	31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature A. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32316

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Mae Shipley				2. Date of Death Month Day Year September 22 2000				3. Time of Death 8:00AM	
	4e. Facility Name (If not institution, give street and number) 310 Main St.				4b. City, Town, or Location of Death New Windsor				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 215-32-7920		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Apr. 30, 1918		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location New Windsor	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 310 Main St.		10f. Zip Code 21776		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) supervisor of quality control		16b. Kind of Business/Industry importer & distributor of internat'l. handcrafts					
	17. Father's Name (First, Middle, Last) John Sier				18. Mother's Name (First, Middle, Maiden Surname) Janie V. Burke					
	19a. Informant's Name/Relationship (Type, Print) Anna M. Myers/ daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Main St. New Windsor, MD 21776					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Methodist Cemetery		20c. Location - City or Town, State Taylorsville, MD					
	21. Signature of Funeral Service Licensee Catherine O. Harker				22. Name and Address of Facility Hartzler Funeral Home 310 Church St., New Windsor, MD 21776					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. congestive heart failure Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 1/2 yrs							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier John O. Harker MD		29c. License number D39296		29d. Date signed (Month, Day, Year) 9/22/2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Ricketts MD CCGH Westminster MD 21157		31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature Anna G Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32317


Certificate of Death

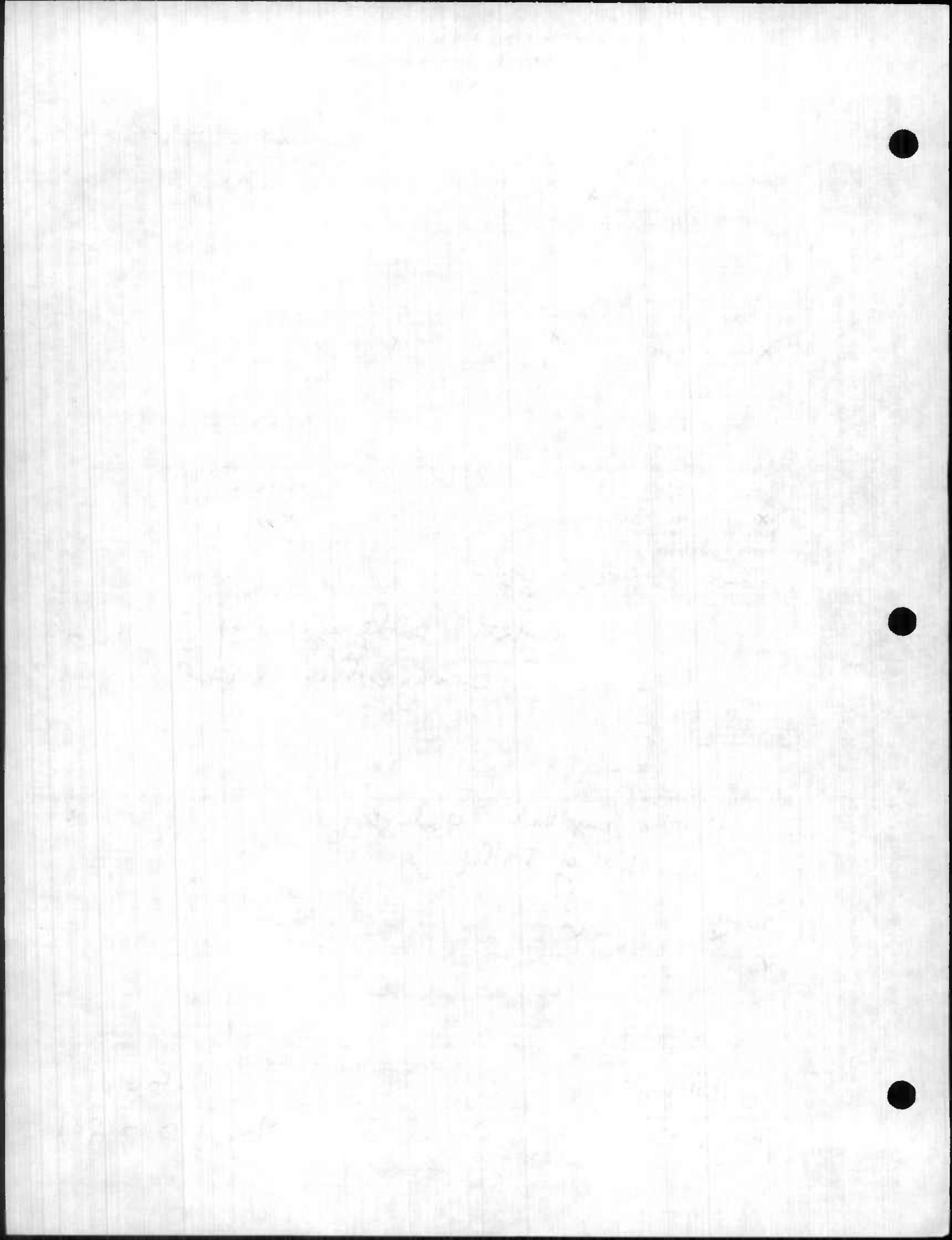
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HERBERT A. STREAKER SR.				2. Date of Death Month Day Year SEP 25 2000			3. Time of Death 3:38A		
	4a. Facility Name (If not institution, give street and number) HOWARD COUNTY GENERAL HOSPITAL				4b. City, Town, or Location of Death COLUMBIA			4c. County of Death HOWARD		
Funeral Director	5. Social Security Number 218-12-7451		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) May 29, 1918		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Howard		10c. City, Town or Location West Friendship				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 13990 Frederick Road				10f. Zip Code 21794		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Agriculture		
	17. Father's Name (First, Middle, Last) John Robert Streaker, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Lillian Virginia Moxley				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Dorothy M. Streaker (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13990 Frederick Road West Friendship, MD 21794					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MT. VIEW CEMETERY		Date 9/29/00		20c. Location - City or Town, State Marriottsville, MD	
	21. Signature of Funeral Service Licensee Brian D. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	Approximate Interval Between Onset and Death 3 hours									
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Post-herpetic Neuralgia							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Steven Geller				29c. License number d34613			29d. Date signed (Month, Day, Year) September 26, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Geller MD 9501 Old Annapolis Rd Elliott City MD 21042									
31. Date filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature Doreen B Sparks						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 32318**
Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Malinda Dora Stanford				2. Date of Death Month September Day 26 Year 2000		3. Time of Death 1416	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 215-07-1365A		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 20 1907	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Fruitland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 109 Moon Glow Road				10f. Zip Code 21826		10g. Citizen of What Country? U.S.A		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry None		
17. Father's Name (First, Middle, Last) Samuel Christopher				18. Mother's Name (First, Middle, Maiden Surname) Lily Waters				
19a. Informant's Name/Relationship (Type, Print) Jonathan Wright (Grandson)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 Moon Glow Rd. Fruitland Md. 21826				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Flower Hill Church		20c. Location - City or Town, State Eden, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>myocardial infarction</i> Due to (or as a consequence of): b. <i>coronary artery disease</i> Due to (or as a consequence of): c. <i>hypertension</i> Due to (or as a consequence of): d. <i>hyperlipidemia</i>								Approximate Interval Between Onset and Death months years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>cardiac arrhythmia end-stage kidney failure</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Dr. C. Tan W. D.				29c. License number D16725		29d. Date signed (Month, Day, Year) 09/26/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAN, CONSTANCE 547-G Riverside Dr, Salisbury, MD 21801								
31. Date filed (Month, Day, Year) SEP 29 2000				32. Registrar's Signature B. Sparks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32319

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LYNN L. TEAL

2. Date of Death
Month Day Year
Sept. 21, 20003. Time of Death
2:20 PM

4a. Facility Name (If not institution, give street and number)

St. Mary's Nursing Home

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral
Director

5. Social Security Number

216 05 9348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 21, 1916

9. Birthplace (State or Foreign Country)

Baltimore MD

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29585 Hearts Desire Drive

10f. Zip Code

20659

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Daniel H. Lewis

18. Mother's Name (First, Middle, Maiden Summe)

Frieda W. Tews

19a. Informant's Name/Relationship (Type, Print)

Lynne E. Donaldson Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29585 Hearts Desire Drive Mechanicsville MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Park

Date

Sept. 26, 2000

20c. Location - City or Town, State

Elkridge Maryland

21. Signature of Funeral Service Licensee

Robert E. Evans

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Road, Bowie, MD 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiopulmonary Failure

Due to (or as a consequence of):

Metabolic Acidosis

Due to (or as a consequence of):

Chronic Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hrs.

days

yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. James P. Jarboe, MD

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

9-22-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. James P. Jarboe, 24035 Three Notch Rd., Hollywood, MD 20636

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32320

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ralph Eugene Talkington				2. Date of Death Month Day Year September 23, 2000				3. Time of Death 0105	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-24-5492		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) March 19, 1927		9. Birthplace (State or Foreign Country) West Virginia	
	10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Forestville			
To Be Completed by Funeral Director	10e. Street and Number 5904 Cheryl Lane				10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1944-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Railroad			
	17. Father's Name (First, Middle, Last) Clemmie Edward Talkington				18. Mother's Name (First, Middle, Maiden Surname) Hulda Hayes					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margaret E. Conway (Friend)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 47706 Forestville, Maryland 20747					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Cem.		20c. Location - City or Town, State Cheltenham, Maryland					
	21. Signature of Funeral Service Licensee <i>Louis L. Hunt</i>				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration pneumonia Due to (or as a consequence of): b. Alzheimer's disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 8 days					
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease Atherosclerotic heart disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Deidra L. Varner, M.D.</i>		29c. License number D33512		29d. Date signed (Month, Day, Year) 9/24/00				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEIDRA L. VARNER, M.D.; 11701 Livingston Rd #101; Ft. Washington, MD									
	31. Date filed (Month, Day, Year) SEP 26 2000				32. Registrar's Signature <i>G. Sparks</i>					

ORIGINAL

Baltimore, Maryland 21215-0036
0105
09/23/00
TALKINGTON, RALPH
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32321

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Ethel Tensch		2. Date of Death Month Day Year September 27, 2000		3. Time of Death 2:40 am
	4a. Facility Name (If not Institution, give street and number) Spa Creek Center Genesis Eldercare		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 578-18-2493	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 10, 1922	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Forestville		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 2814 Viceroy Avenue		10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Purchasing Agent
	17. Father's Name (First, Middle, Last) Milton R. Russell		18. Mother's Name (First, Middle, Maiden Surname) Ethel Marie Neff		19a. Informant's Name/Relationship (Type, Print) Richard D. Swain - Son
	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4476 Owensville-Sudley Road, Harwood, MD 20776		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery
	20c. Date 9/30/2000		20d. Location - City or Town, State Suitland, Maryland		21. Signature of Funeral Service Licensed
	22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781		23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Due to (or as a consequence of): EMPHYSEMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RECENT MRSA BRONCHITIS HYPOTHYROID		Approximate Interval Between Onset and Death 1 month YEARS
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier David S. Krimins		29c. License number 023142		29d. Date signed (Month, Day, Year) September 27, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Krimins, M.D., 104 Ridgely Avenue, Ste. #301, Annapolis, MD 21401					
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32322

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Morgan Tann

2. Date of Death

September 17 2000

3. Time of Death

4:50 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Northwest Hospital

4b. City, Town, or Location of Death

Randelstown

4c. County of Death

Baltimore

5. Social Security Number

496-18-0670

6. Sex

M 20 F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

2-20-15

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

N.C.

10b. County

Cabarrus

10c. City, Town or Location

Concord

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

7701 Untz Rd

10f. Zip Code

28025

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Minister

16b. Kind of Business/Industry

Clergy

17. Father's Name (First, Middle, Last)

William Tann

18. Mother's Name (First, Middle, Maiden Summa)

Bonita Morgan

19a. Informant's Name/Relationship (Type, Print)

Marie P. Tann (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7701 Untz Rd Concord NC

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gethsemane Cemetery

Data

9-22-00

20c. Location - City or Town, State

Charlotte N.C.

21. Signature of Funeral Service Licensee

Roger P. Tann

22. Name and Address of Facility

Long & Son Mortuary Svc
2312 Beatties Ford Rd Charlotte NC 28216

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiac Arrhythmia

Approximate Interval Between Onset and Death

One hour

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Dz

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation
20 Accident 60 Could not be determined
30 Suicide
40 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lyle Campbell M.D.

29c. License number

D47773

29d. Date signed (Month, Day, Year)

Sept 11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lyle Campbell M.D. 5401 Old Court Rd Randelstown Md 21133

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32323

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Carrie L. Thompson

2. Date of Death

9 - 26-2000

3. Time of Death

6:20 P.M.

4a. Facility Name (If not institution, give street and number)

Southern md. Hospital

4b. City, Town, or Location of Death

Clinton, Md.

4c. County of Death

P.G. County

Funeral
Director

5. Social Security Number

075-22-4866

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

10-26-1901

9. Birthplace (State or Foreign Country)

Pisgah, Md.

Usual Residence of Decedent

10a. State

Md. P.G. County

10b. County

10c. City, Town or Location

Temple Hills, Md.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2216-Iverson St

10f. Zip Code

20748

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James Brown

18. Mother's Name (First, Middle, Maiden Surname)

Alice Bowman Brown

19a. Informant's Name/Relationship (Type, Print)

Herman Warren Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2216-Iverson St, Temple Hills Md. 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smiths Chapel

Date

9-30-00 P. Charles County

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lafayette E. Montgomery

22. Name and Address of Facility

Tyrone J. Young Funeral Service 20011
719 Kennedy St, N.W. Wash, D.C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pulmonary Embolism

Due to (or as a consequence of):

b.

Circulation sent to heart

Due to (or as a consequence of):

c.

Electrolyte imbalance

Due to (or as a consequence of):

d.

pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

29. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Lafayette E. Montgomery

29c. License number

D14156

29d. Date signed (Month, Day, Year)

9-27-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Georg W. Wontorez, W.D. 1300 Mercantile Lane - Largo - MD 20774

State
Registrar

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

Lafayette E. Montgomery

ORIGINAL

Baltimore, Maryland 21215-0036

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,

Thompson, Carrie # 971328 @ 1820 Dr. Mortanez 9-26-00

00 32324

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #8,7 10/02/00 State of Maryland / Department of Health and Mental Hygiene
Amended #14,02/25/2000, WCHD, HLC Certificate of Death

Reg. No.

00 32325

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mildred Virginia Tasker				2. Date of Death Month Day Year Sept. 23 2000				3. Time of Death 0125				
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George				
Funeral Director	5. Social Security Number 220-01-7833		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 88 Yrs.		If Under 1 Year Months Days 1912		8. Date of Birth (Month, Day, Year) Aug. 28 1913		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent												
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 117 Second Street				10f. Zip Code 21801				10g. Citizen of What Country? U.S.A					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black U.S.A				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer				16b. Kind of Business/Industry None					
17. Father's Name (First, Middle, Last) Archie Lee						18. Mother's Name (First, Middle, Maiden Surname) Mary Wigfall							
19a. Informant's Name/Relationship (Type, Print) Secunda Perry (Grand Daughter)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1206 W. Riverview Rd. Fort Washington, Md. 20744							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Acres				Date 9/30/00		20c. Location - City or Town, State Salisbury, Md.			
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Failure, Irreversible 1-2 wks Due to (or as a consequence of): b. Conductive Myocardopathy 2-3 mms. Due to (or as a consequence of): c. Coronary Artery Disease and 20 yrs Due to (or as a consequence of): d. Myocardial Fibrosis - Dilated Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration Pneumonia, generalized Dehydration, severe Hypoxemia, Plural Effusion										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Richard A. Farson MD				29c. License number DO 2237 MD		29d. Date signed (Month, Day, Year) 9/23/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Farson, MD 12825 Old Fort Rd Ft. Wash MD 20744													
31. Date filed (Month, Day, Year) SEP 25 2000				32. Registrar's Signature <i>[Signature]</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 8055.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

TASKER, MILDRED 09/23/00 0125

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32326

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alton Tyler		2. Date of Death Month September Day 30 , Year 2000		3. Time of Death 1800
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert
Funeral Director	5. Social Security Number 212-54-6660	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 14, 1949		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10a. State Maryland	10b. County Calvert	St. Leonard		
	10e. Street and Number 5906 Hillside Road		10f. Zip Code 20685		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1967- If Yes, Give Year or Dates: 1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Polygraph Specialist		16b. Kind of Business/Industry Secret Service		
	17. Father's Name (First, Middle, Last) Joseph Tyler		18. Mother's Name (First, Middle, Maiden Surname) Louiseana Chew		
	19a. Informant's Name/Relationship (Type, Print) Patsy Tyler/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5906 Hillside Road St. Leonard, MD 20685		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Solid Rock Church Cem.		20c. Location - City or Town, State Port Republic, MD
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Carcinoid, malignant				Approximate Interval Between Onset and Death 8 months
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year)					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 					
29c. License number D39920					
29d. Date signed (Month, Day, Year) 10-2-00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Brooks, M.D. Prince Frederick, MD 20678					
31. Date filed (Month, Day, Year) OCT 02 2000					
32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32327

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32328

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roma P. Vierbuchen				2. Date of Death Month Day Year September 24, 2000				3. Time of Death 2:15PM		
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 464-09-8735		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) June 8, 1908		9. Birthplace (State or Foreign Country) Texas		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Charles		10c. City, Town or Location Hughesville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6055 Trotters Glen Drive				10f. Zip Code 20637		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Clarence Elmer Perry				18. Mother's Name (First, Middle, Maiden Surname) Laura Mae Nanny						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marilyn Furr/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as item 10						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oakwood Cemetery		Date 9/27/2000		20c. Location - City or Town, State Fort Worth, Texas				
	21. Signature of Funeral Service Licensee George P. Kalas				22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>bilateral pneumonia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 days		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia - Hypertension - Diabetes</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Sam T. Tellawi				29c. License number D34274				29d. Date signed (Month, Day, Year) 9.25.2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ESSAM TELLAWI 7700 Old Branch Av B-102 Clinton, Md											
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature B. Sparks									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32329

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LENA RICHMOND WILLIAMS				2. Date of Death Month 9 Day 22 Year 2000		3. Time of Death 11:47 PM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 410-78-7924		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 5, 1944	
	9. Birthplace (State or Foreign Country) Mississippi		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
Usual Residence of Decedent								
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 1701 Willow Oaks Court								
10f. Zip Code 20721								
10g. Citizen of What Country? U.S.A.								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Black			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator		
16b. Kind of Business/Industry Private			17. Father's Name (First, Middle, Last) Robert Richmond			18. Mother's Name (First, Middle, Maiden Surname) Alean Taylor		
19a. Informant's Name/Relationship (Type, Print) Robert L. Williams/Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Willow Oaks Court, Mitchellville, MD 20721					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Ceme.			20c. Location - City or Town, State Cheltenham, Maryland		
21. Signature of Funeral Service Licensee Nancy A. Perente			22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Left Hemisphere Cerebral Infarction Due to (or as a consequence of): b. Cerebral Vasculitis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Approximate Interval Between Onset and Death 2 weeks 18 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Cerebral Infarctions								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Wesley B. Mason			29c. License number D22235			29d. Date signed (Month, Day, Year) 9/23/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wesley B. Mason MD, 10810 Connecticut Ave, Kensington, MD, 20895								
31. Date filed (Month, Day, Year) SEP 26 2000			32. Registrar's Signature [Signature]					

ORIGINAL

1957-1958

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and the results of the various projects. It is a general overview of the work done during the year and is intended to give a general impression of the work done and the results achieved.

2. The second part of the report deals with the specific work done by the various departments. It is a detailed account of the work done by each department and the results achieved. It is a summary of the work done by each department and is intended to give a detailed impression of the work done and the results achieved.

3. The third part of the report deals with the financial situation of the country. It is a summary of the financial situation of the country and the results achieved. It is a summary of the financial situation of the country and is intended to give a detailed impression of the financial situation and the results achieved.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32330

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Louise Willis				2. Date of Death Month Day Year Sept 22, 2000				3. Time of Death 12:53 AM			
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 213 42 9650		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) June 20, 1944		9. Birthplace (State or Foreign Country) Washington DC			
	Usual Residence of Decedent		10a. State MD		10b. County Prince George's		10c. City, Town or Location Aguasco		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 16101 St. Phillips Road		10f. Zip Code 20608		10g. Citizen of What Country? United States								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Typist		16b. Kind of Business/Industry Clerical								
17. Father's Name (First, Middle, Last) John Edwin Soper				18. Mother's Name (First, Middle, Maiden Surname) Ruth Estelle Spaulding								
19a. Informant's Name/Relationship (Type, Print) Richard Willis (HUSBAND)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16101 St. Phillips Road, Aquasco, Maryland 20608								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date Sept 26, 2000		20c. Location - City or Town, State Suitland, Maryland				
21. Signature of Funeral Service Licensee Lee R. Patten				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. META STATIC CARCINOMA Due to (or as a consequence of): b. MALIGNANT ASCITES Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier R. S. Santos MD							29c. License number D27744		29d. Date signed (Month, Day, Year) 9-22-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. R. S. Santos, MD CLINTON MD												
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature S. Sparks										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 32331**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Brian Jay Waby				2. Date of Death Month 9 Day 25 Year 2000		3. Time of Death 645 PM	
	4a. Facility Name (If not Institution, give street and number) Deaton Specialty Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 577 92 6112		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 30 Yrs.		8. Date of Birth (Month, Day, Year) Dec 9, 1969	
	9. Birthplace (State or Foreign Country) Washington DC		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 601 S. Charles Street		10f. Zip Code 21230		10g. Citizen of What Country? United States		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None		16b. Kind of Business/Industry None				
17. Father's Name (First, Middle, Last) Conrad L. Waby				18. Mother's Name (First, Middle, Maiden Surname) Judith M. Hansel				
19a. Informant's Name/Relationship (Type, Print) Conrad L. Waby/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9213 Dandelion Lane, Upper Marlboro, Maryland 20772				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory Sept 30, 2000		20c. Location - City or Town, State Clinton, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20375				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Seizure disorder Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death 5 minutes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mitochondrial Encephalopathy Seizure disorder							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Chronic Hospital		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD		29c. License number D38675		29d. Date signed (Month, Day, Year) 9/26/2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202								
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32332

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond Ray Ward				2. Date of Death Month 09 Day 27 Year 2000				3. Time of Death 0120 AM			
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 579-10-6662		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) May 15, 1915		9. Birthplace (State or Foreign Country) Md District Heights			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location District Heights				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 2160 County Rd.				10f. Zip Code 20747				10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942/45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian				16b. Kind of Business/Industry United States Gov't			
	17. Father's Name (First, Middle, Last) Jeremiah Ward				18. Mother's Name (First, Middle, Maiden Surname) Eliza Hawkins							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Louise Wright Ward/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2160 County Rd. District Heights, Md. 20747							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland States Veterans				Date 10/5/00		20c. Location - City or Town, State Cheltenham, Md.	
	21. Signature of Funeral Service Licensee Kurt A. Sharpe MD0005				22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Bilateral pneumonia Due to (or as a consequence of): Chronic obstructive lung disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death days years			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute or chronic renal failure, coronary artery disease, hypertension, Sick sinus syndr, STP permanent pacemaker								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier R. Rustagi MD				29c. License number D24720		29d. Date signed (Month, Day, Year) 9-27-00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6132 Landover Road, Cheverly MD 20785				31. Date filed (Month, Day, Year) SEP 29 2000				32. Registrar's Signature S. Sparks			
	State Registrar											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32333

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MINNIE WILLIAMS

2. Date of Death

Month Day Year
September 21 2000

3. Time of Death

8:15 AM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-30-6863

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 2, 1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Fort Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6801 Bock Road

10f. Zip Code

20744

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Worker

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Linwood Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Patsy Dixon

19a. Informant's Name/Relationship (Type, Print)

Andrew Chance/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6308 Willow Way, Clinton, Maryland 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

09/28
2000

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

acute cardiac arrest

Approximate Interval Between Onset and Death

seconds

Due to (or as a consequence of):

b.

congestive heart failure

days

Due to (or as a consequence of):

c.

hypertension

year

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

Renal insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. Williams MD

29c. License number

D 53411

29d. Date signed (Month, Day, Year)

September 24th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JC Mbsadi MD, 3060 Mitchellville Rd # 103 Bowie MD 20708

State
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Found a Lamb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32334

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ivan Rolando Wiggins				2. Date of Death Month Day Year SEPTEMBER 23, 2000		3. Time of Death 00:22 AM	
	4a. Facility Name (If not institution, give street and number) PENNSYLVANIA AVENUE AND SUNNYSIDE AVENUE				4b. City, Town, or Location of Death Suitland		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 579-02-3692	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 22 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 6, 1978	9. Birthplace (State or Foreign) Washington, D.C.	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Forestville			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 8400 Lenaskin Ln.			10f. Zip Code 20747		10g. Citizen of What Country? United States		
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Carl R. Wiggins				18. Mother's Name (First, Middle, Maiden Surname) Iris Zeigler			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Iris Zeigler / Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8400 Lenaskin Ln. Forestville, Md. 20747			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem.		20c. Date 9/28/00		20d. Location - City or Town, State Suitland, Md.	
	21. Signature of Funeral Service Licensed Kertha Savage Moss		22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Head Injuries Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 4-23-00		28b. Time of Injury 0018 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway		28e. Location (Street and Number or Rural Route Number, City or Town, State) Pennsylvania Ave				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier JHL		29c. License number OCME		29d. Date signed (Month, Day, Year) SEPTEMBER 23, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature B. Spaul						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1947

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32335

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lula Osborn Ward				2. Date of Death Month Day Year Sept 19, 2000		3. Time of Death 12:47 pm		
	4a. Facility Name (If not institution, give street and number) 815 Clearview Avenue				4b. City, Town, or Location of Death Hampstead		4c. County of Death Carroll		
Funeral Director	5. Social Security Number 218-24-9888		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Jun 13, 1925		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Hampstead		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 815 Clearview Avenue		10f. Zip Code 21074		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home					
17. Father's Name (First, Middle, Last) Garrett Osborn				18. Mother's Name (First, Middle, Maiden Surname) Nellie Jane Metlock					
19a. Informant's Name/Relationship (Type, Print) Arthur Ward, son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 175, Hampstead, MD 21074					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sams Creek Cemetery		Date 9/22		20c. Location - City or Town, State Dennings, MD			
21. Signature of Funeral Service Licensee Eline		22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 16 years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Deogracias V. Faustino, M.D.		29c. License number D12901		29d. Date signed (Month, Day, Year) 9/20/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Deogracias V. Faustino, M.D. 4111 L. Beckleysville Rd Hampstead, MD 21074		31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature B Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32336

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE WINFIELD WILLIAMS, SR.

2. Date of Death

Month Day Year
Sept. 22, 2000

3. Time of Death

9:05 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

220-01-7888

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JULY 26, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

506 PACIFIC AVE.

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
4

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OWNER / OPERATOR

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

CLAYTON L. WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

LAVINIA L. CORKRAN

19a. Informant's Name/Relationship (Type, Print)

JOSEPHINE M. WILLIAMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

506 PACIFIC AVE. SALISBURY, MD 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WICOMICO MEMORIAL PARK

Date

9/26/00

20c. Location - City or Town, State

SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee

B. Keith P. Lynn, CFS

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC.

705 E. MAIN ST.

SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson's Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Egophony Structure
Pneumonia (Recent)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. Keith P. Lynn MD

29c. License number

D 39813

29d. Date signed (Month, Day, Year)

9/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Atkins

and

1104 HEALTHWAY DR., SALISBURY, MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Sparks

GEORGE WINFIELD WILLIAMS
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit


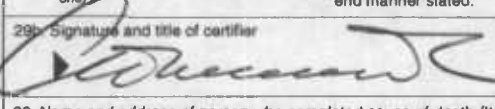
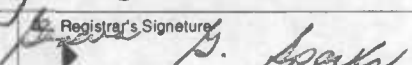
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32337

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN FRANCES YOWELL		2. Date of Death Month September Day 22 Year 2000		3. Time of Death 6:15 PM
	4a. Facility Name (If not institution, give street and number) 506 Washington Street		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico
Funeral Director	5. Social Security Number 217-44-1301	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) November 20, 1918		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 506 Washington Street		10f. Zip Code 21804	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Health Care		17. Father's Name (First, Middle, Last) Raymond T. Howard	
18. Mother's Name (First, Middle, Maiden Surname) Edna Mae Nichols		19a. Informant's Name/Relationship (Type, Print) Jo Ann Nelson/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Calvery Court, Centerville, MD 21617	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		20c. Location - City or Town, State Salisbury, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC LIVER CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 months		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier 		29c. License number 046257		29d. Date signed (Month, Day, Year) 9/25/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9714 Heathway Drive Berlin, MD 21811					
31. Date filed (Month, Day, Year) SEP 26 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

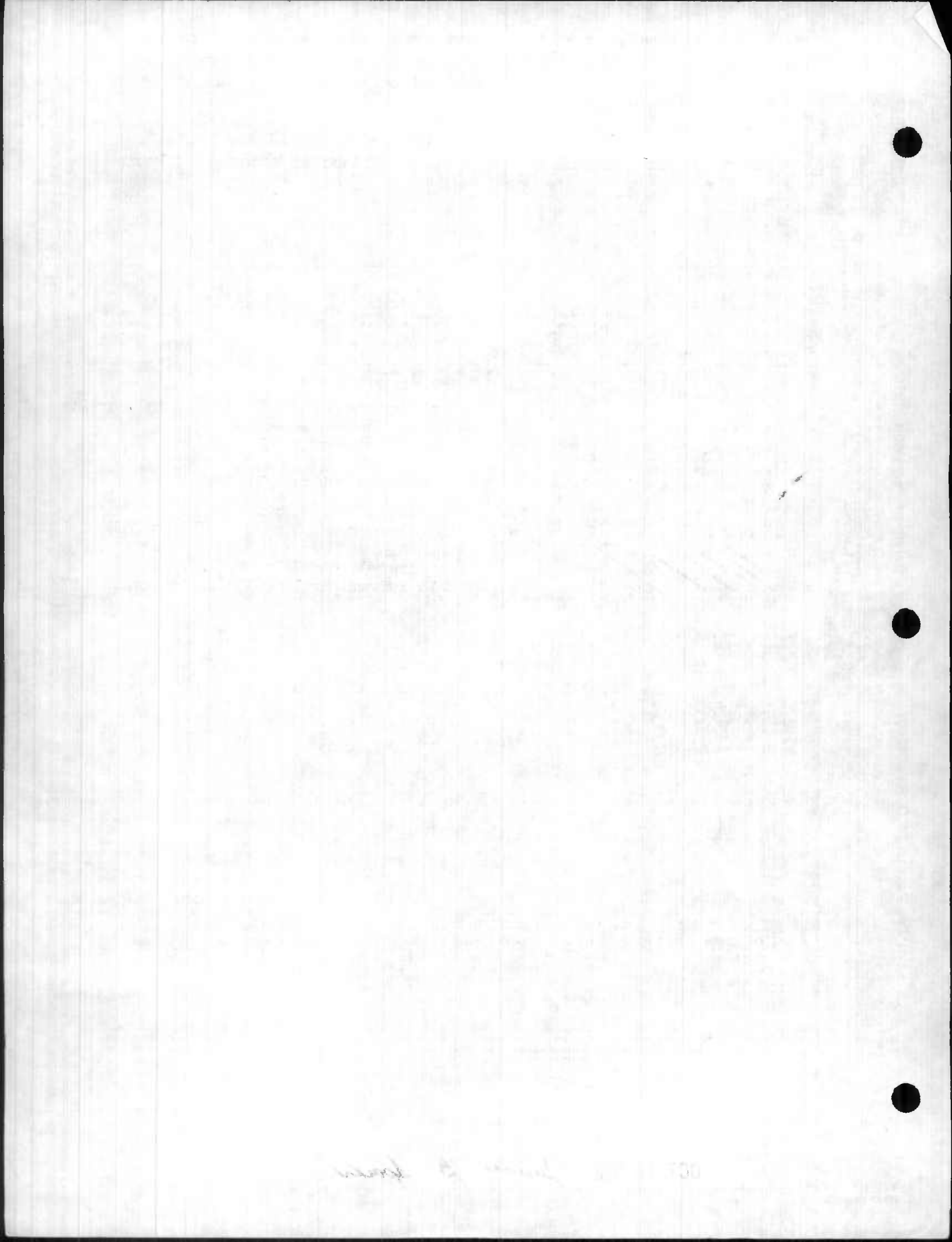
00 32338

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT Charles YOUNG		2. Date of Death Month OCTOBER Day 2 Year 2000		3. Time of Death 9:42 A.M.
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital		4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert
Funeral Director	5. Social Security Number 577-18-3603	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 7, 1925		9. Birthplace (State or Foreign Country) Washington, DC		
Usual Residence of Decedent					
10a. State MD		10b. County Calvert		10c. City, Town or Location Owings	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 6380 Dant Drive			10f. Zip Code 20736		10g. Citizen of What Country? U.S.A.
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Letter Carrier		16b. Kind of Business/Industry US Postal Service
17. Father's Name (First, Middle, Last) George A. Young			18. Mother's Name (First, Middle, Maiden Surname) Dorothy Daly		
19a. Informant's Name/Relationship (Type, Print) Ruth A. Young (Wife)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6380 Dant Drive Owings, MD 20736		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Respiratory Failure Due to (or as a consequence of): b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 033123		29d. Date signed (Month, Day, Year) 10-2-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. JONATHAN LOWENTHAL, MD PRINCE FREDERICK, MD 20678					
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32339

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward C. Benner				2. Date of Death Month October Day 10 Year 2000		3. Time of Death 1230	
	4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 212-10-9932		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) July 22, 1916	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County n/a		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 903 Cooks Lane Apt. 2D		10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Captain		16b. Kind of Business/Industry Security				
17. Father's Name (First, Middle, Last) Christian Benner				18. Mother's Name (First, Middle, Maiden Surname) Anna Elizabeth Bachman				
19a. Informant's Name/Relationship (Type, Print) Darlene L. Klenz / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16355 Gebhardt Road, Brookfield, Wisconsin 53005				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. Location - City or Town, State 10/16/00 Baltimore, Maryland				
21. Signature of Funeral Service Licensee Quantia R Thomas		22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and Title of certifier Scott Bergeson M.D.				29c. License number 00055849		29d. Date signed (Month, Day, Year) October 16 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SCOTT BERGESON ST. AGNES HOSPITAL								
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature Sparks				

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State of Maryland / Department of Health and Mental Hygiene

00 32340

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Evelyn Lois Bentley</i>			2. Date of Death Month Day Year <i>Oct. 9 2000</i>		3. Time of Death <i>1:55pm</i>		
	4a. Facility Name (If not institution, give street and number) <i>9 Overbrook Dr.</i>			4b. City, Town, or Location of Death <i>Bel Air</i>		4c. County of Death <i>Harford</i>		
Funeral Director	5. Social Security Number <i>218-38-3354</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>59</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>June 15, 1941</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>Md</i>		10b. County <i>Harford</i>		10c. City, Town or Location <i>Bel Air</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>9 Overbrook Dr.</i>		10f. Zip Code <i>21014</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>-</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>telephone operator</i>		16b. Kind of Business/Industry <i>C+P Telephone</i>		17. Father's Name (First, Middle, Last) <i>unknown</i>	
	18. Mother's Name (First, Middle, Maiden Surname) <i>Florence E. Hoffnagle</i>		19a. Informant's Name/Relationship (Type, Print) <i>Mary E. Bentley</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9 Overbrook Dr. Bel Air, Md 21014</i>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Zion Cemetery</i>		20c. Location - City or Town, State <i>Oct. 12 2000 Churchville, Md</i>		21. Signature of Funeral Service Licensee <i>John S. Wells</i>		22. Name and Address of Facility <i>Evans Funeral Chapel - Bel Air 3 Newport Dr. Forest Hill, Md 21050</i>	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. Ovarian Carcinoma</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>		Approximate Interval Between Onset and Death <i>39 mos.</i>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
State Registrar	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Michael E. McCallum</i>	
	29c. License number <i>D41490</i>		29d. Date signed (Month, Day, Year) <i>10-11-2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dr. Michael McCallum 9105 Franklin Square Drive Balto., Md. 21237</i>		31. Data filed (Month, Day, Year) <i>OCT 13 2000</i>	
32. Registrar's Signature <i>Benjamin Sparks</i>								

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene 00 32341

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Susie Biggers</i>				2. Date of Death Month <i>October</i> Day <i>11</i> Year <i>2000</i>		3. Time of Death <i>1:40A</i>	
	4a. Facility Name (If not institution, give street and number) <i>Meray Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>212-30-3095</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>07-17-20</i>	
	Usual Residence of Decedent		10a. State <i>MD</i>		10b. County <i>NA</i>		10c. City, Town or Location <i>Baltimore</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>3509 Clifftmont Avenue</i>		10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>High School</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>		16b. Kind of Business/Industry <i>in Home</i>			
	17. Father's Name (First, Middle, Last) <i>Tom Bruce</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Maggie Spencer Randallstown</i>					
	19a. Informant's Name/Relationship (Type, Print) <i>Rebecca Biggers</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3558 Carriage Hill Circle Apt. T-2 MD. 21133</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Baltimore Cemetery</i>		20c. Location - City or Town, State <i>10-14-2000 Baltimore, MD</i>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>Dilated Cardiomyopathy</i> Due to (or as a consequence of): b. <i>Coronary Artery Disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Cerebrovascular Accident</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>P12370</i>		
29d. Date signed (Month, Day, Year) <i>October 11, 2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kimberly L. Bolling M.D. Meray Hospital 301 Saint Paul, Balt. MD</i>		31. Date filed (Month, Day, Year) <i>OCT 13 2000</i>		32. Registrar's Signature <i>[Signature]</i>		

Two

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State of Maryland / Department of Health and Mental Hygiene 00 32342

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James H. Booker				2. Date of Death Month Oct. Day 08 Year 2000		3. Time of Death 0900	
	4a. Facility Name (If not institution, give street and number) Deaton Specialty Home Hosp.				4b. City, Town, or Location of Death Baltimore		4c. County of Death NA	
Funeral Director	5. Social Security Number 218-07-5282		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08-24-18	9. Birthplace (State or Foreign Country) PA
	Usual Residence of Decedent							
10a. State MD		10b. County NA		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1527 N. Washington Street				10f. Zip Code 21213		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipyard		16b. Kind of Business/Industry Bethlehem Steel Co		
17. Father's Name (First, Middle, Last) Herbert Booker				18. Mother's Name (First, Middle, Maiden Surname) Annie J. Brown				
19a. Informant's Name/Relationship (Type, Print) Annie Booker				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 1527 N. Washington Street Baltimore, MD.				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		Date 10-13-2000		20c. Location - City or Town, State Dundalk, MD
21. Signature of Funeral Service Licensee Bernard D. Johnson				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. END STAGE RENAL DISEASE Due to (or as a consequence of): b. DIABETES MELLITUS Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 6 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE DEMEMENTIA						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Waz MD		29c. License number 047945		29d. Date signed (Month, Day, Year) OCT 09 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARIS AHEM 9101 FRANKLIN SQUARE DRIVE BALTIMORE MD 21237								
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature Bernard D. Sparks				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

State
Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 32343

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Schooler Brewer

2. Date of Death

Month Day Year
October 11, 2000

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore Co.

Funeral
Director

5. Social Security Number

213-20-4009

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 15, 1925

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19 A Mopec Circle

10f. Zip Code

21236

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Buyer

16b. Kind of Business/Industry

Antiques

17. Father's Name (First, Middle, Last)

George Ward Brewer

18. Mother's Name (First, Middle, Maiden Surname)

Virgie Victoria Schooler

19a. Informant's Name/Relationship (Type, Print)

Melinda Laupert(Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 Osyter Cove Drive Graysonville, Maryland 21638

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moreland Memorial Park

Date

10/14/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Meningioma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

10/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

[Signature]

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

October 11, 2000 3:00 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Howard Brewer

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32344

amend item 23a,ptII,27 per me G788 10/16/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ralph Bryant				2. Date of Death Month Day Year SEPTEMBER 24 2000				3. Time of Death 9:55 A		
	4a. Facility Name (If not institution, give street and number) 3001 S. HANOVER ST.				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death		
Funeral Director	5. Social Security Number unk		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) Nov 21, 1951		9. Birthplace (State or Foreign Country) unk		
	Usual Residence of Decedent										
10a. State MD		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 740 Dolphin Street				10f. Zip Code 21217				10g. Citizen of What Country? USA			
11. Marital Status unk 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk				16b. Kind of Business/Industry unk			
17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk							
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State							
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. DIABETIC KETOACIDOSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE								23b. Did tobacco use contribute to the causa of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Dennis J. Chafeno				29c. License number O.C.M.E				29d. Date signed (Month, Day, Year) SEPTEMBER 25, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis J. Chafeno 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature Dennis J. Chafeno									

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32345

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mack K. Bowman Sr.

2. Date of Death

Month Day Year
October 6 2000

3. Time of Death

8:40 P.M.

4a. Facility Name (If not institution, give street and number)

Mariner Health of North Arundel

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

245 32 6213

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 3, 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

108 - 3rd Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Yardmaster

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

William Jason Bowman

18. Mother's Name (First, Middle, Maiden Surname)

Pansie Benfield

19a. Informant's Name/Relationship (Type, Print)

Mary Bowman / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 - 3rd Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Park

Date

10/10/00

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG & CANCER with Metastasis

Due to (or as a consequence of):

b. Rheumatoid Arthritis

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 year

20 years

5 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D20094

29d. Date signed (Month, Day, Year)

10/09/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ellott Gorbaly and 7845 Oakwood Rd., Glen Burnie, Md, 21061

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Ryan Colby

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27, per me G788 10/17/00 yf

Certificate of Death

Reg. No.

00 32346

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RYAN DEVON COLBY				2. Date of Death Month October Day 09 Year 2000		3. Time of Death 12:45 P.M.	
	4a. Facility Name (If not institution, give street and number) Saint Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-13-2801	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 14 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) July 31, 1986	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 1801 N. DUKELAND STREET				10f. Zip Code 21216		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) ROBERT COLBY				18. Mother's Name (First, Middle, Maiden Surname) LINDA GIBSON			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ROBERT COLBY / Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 N. DukeLand Street Baltimore, Md 21216			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lion Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 10-14-2000	
	21. Signature of Funeral Service Licensee Geray Harris		22. Name and Address of Facility CHAIRMAN - HARRIS Funeral Home 5240 PEISTERSTOWN ROAD BALTIMORE, MD 21215					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. DIABETIC KETOACIDOSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier Stephen S. Radentz, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 10, 2000	
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201							
	31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature B. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32347

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARTHUR CHAMBERS				2. Date of Death Month Day Year SEP 30 2000		3. Time of Death 10:25 a.m.		
	4a. Facility Name (If not institution, give street and number) Saint Agnes Health Care 900 Caton Ave				4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 142-24-5891		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Aug 13, 1932		
	9. Birthplace (State or Foreign Country) unk		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 701 Edmondson Avenue		10f. Zip Code 21228		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk		17. Father's Name (First, Middle, Last) unk		18. Mother's Name (First, Middle, Maiden Surname) unk	
19a. Informant's Name/Relationship (Type, Print) St. Agnes Hospital		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD 21229		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, Md 21201		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Aspiration pneumonia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 month		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Michael Steppie Resident	
29c. License number P13599		29d. Date signed (Month, Day, Year) SEP 30 th 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Steppie 900 Caton Ave, Baltimore 21229		31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature D. Sparks	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32348

Reg. No.

Amend Item 10e per FH,788,10/13/00

9:40 pm

10-10-00

COLUMBUS CANNADY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner
Funeral Director

1. Decedent's Name (First, Middle, Last) COLUMBUS C. CANNADY, JR.				2. Date of Death Month OCT Day 10 Year 2000		3. Time of Death 9:40 P.M.	
4a. Facility Name (If not institution, give street and number) JOSEPH RITCHIE Hospice				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 214-38-1393		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAR. 2, 1941	
9. Birthplace (State or Foreign Country) MARYLAND							
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 812 227 White/lock street				10f. Zip Code 21217		10g. Citizen of What Country? USA	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) 12th grade				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Whiting Turner	
17. Father's Name (First, Middle, Last) Columbus C. Cannady, Sr				18. Mother's Name (First, Middle, Maiden Surname) Lorraine Hardy			
19a. Informant's Name/Relationship (Type, Print) Lillian Billy /sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11909 Garrison Forest Road Swings Mills, Md 21117			
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) David Ridge Cemetery		20c. Location - City or Town, State 10/14/2000 Pikesville, Maryland		20d. Date	
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility 5340 REISTERSTOWN ROAD BALTIMORE, Maryland 21015			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Constriction of the liver Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							Approximate Interval Between Onset and Death Years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
						24a. Was an autopsy performed? 1 Yes 2 No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice					
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]				29c. License number DO00 8583		29d. Date signed (Month, Day, Year) 10/11/2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. William Benedict, Joseph Ritchie Hospice							
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature [Signature]			

Wayne T. Cropper

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32349

amend item 23a,27 per me G788 10/23/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Wayne T. Cropper</u>				2. Date of Death Month <u>October</u> Day <u>10</u> , Year <u>2000</u>		3. Time of Death <u>1:28 P.M.</u>																													
	4a. Facility Name (If not institution, give street and number) <u>Good Samaritan Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>																													
Funeral Director	5. Social Security Number <u>212-44-4845</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>55</u> Yrs.		8. Date of Birth Month <u>Oct.</u> Day <u>29</u> , Year <u>1944</u>																													
	Usual Residence of Decedent		9. Birthplace (State or Foreign) <u>Maryland</u>		10. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
To Be Completed by Funeral Director	10a. State <u>Md</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Parkville</u>																															
	10e. Street and Number <u>8922 1/2 Old Harford Rd.</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>																													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>																													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>manager</u>		16b. Kind of Business/Industry <u>High's Store</u>																															
	17. Father's Name (First, Middle, Last) <u>Thomas W. Cropper</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Louise Tindall</u>																															
	19a. Informant's Name/Relationship (Type, Print) <u>Patricia A. Cropper</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>8722 1/2 Old Harford Rd. Baltimore, Md 21234</u>																															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Moreland Mem. Park</u>		20c. Location - City or Town, State <u>Parkville, Md</u>		20d. Date <u>Oct. 14</u>																													
	21. Signature of Funeral Service Licensee <u>Krista J. Wells</u>				22. Name and Address of Facility <u>Evans Funeral Chapel</u> <u>8800 Harford Rd. Baltimore, Md 21234</u>																															
	25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																			
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td colspan="6">ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</td> </tr> <tr> <td>b.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="6">Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						b.	Due to (or as a consequence of):						c.	Due to (or as a consequence of):						d.	Due to (or as a consequence of):				
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE																																		
	b.	Due to (or as a consequence of):																																		
	c.	Due to (or as a consequence of):																																		
	d.	Due to (or as a consequence of):																																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																				
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																				
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																																				
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																														
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																														
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																				
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>O.C.M.E.</u>		29d. Date signed (Month, Day, Year) <u>October 11, 2000</u>																														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>J. CARON LOCKER, MD</u> <u>111 Penn Street, Baltimore, Maryland 21201</u>																																				
31. Date filed (Month, Day, Year) <u>OCT 13 2000</u>				32. Registrar's Signature <u>[Signature]</u>																																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

00 32350

Reg. No.

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32351

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John A. Cerro		2. Date of Death Month October Day 7 Year 2000		3. Time of Death 4:30 AM
	4a. Facility Name (If not institution, give street and number) Mercy at Stella Maris		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-16-2375	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Feb. 16, 1925		9. Birthplace (State or Foreign Country) Md		
Usual Residence of Decedent					
10a. State Md.		10b. County Baltimore		10c. City, Town or Location Dundalk	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 8029 Park Haven Rd.			10f. Zip Code 21222		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 yrs College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bricklayer		16b. Kind of Business/Industry Mason	
17. Father's Name (First, Middle, Last) Vincent Cerro			18. Mother's Name (First, Middle, Maiden Surname) Carmella Sponzello		
19a. Informant's Name/Relationship (Type, Print) Ann Cerro wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8029 Park Haven Rd. Dundalk, Md. 21222		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill		20c. Location - City or Town, State Oct 10 2000 Middle River, Md.	
21. Signature of Funeral Service Licensee Anthony Connelly		22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line)					
Immediate Cause (Final disease or condition resulting in death)		a. Leung Cancer		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. _____		Due to (or as a consequence of):	
		c. _____		Due to (or as a consequence of):	
		d. _____			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Restrictive Cardiomyopathy Congestive Heart Failure					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice			
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Dr. [Signature]		29c. License number D40854		29d. Date signed (Month, Day, Year) October 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 ST PAUL PI BALTIMORE, MD 21202					
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32352

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Annabel Cramer

2. Date of Death

October 9 2000

3. Time of Death

8:00P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice Center

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

276-07-3428

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/02/1915

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7006 Knighthood Lane

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

A. J. Haire

18. Mother's Name (First, Middle, Maiden Summa)

Alice Glee

19a. Informant's Name/Relationship (Type, Print)

Claudia Tufano - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7006 Knighthood Lane Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mansfield Memorial Park

Date

10/13

20c. Location - City or Town, State

Mansfield, Ohio

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home

736 Edmondson Ave Baltimore, MD 21228

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. End Stage Dementia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

10/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Tariq Mahmood

October 9, 2000 8:00 p.m.
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show
any injury or other traumatic event, the Medical Examiner must be notified at
800-368-5800.Physician
/Medical
ExaminerAnnabel Cramer
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#30 perDVRG788 10/13/2000 EW
Amended Item#17 perFHG788 10/13/2000 EW

State of Maryland / Department of Health and Mental Hygiene

00 32353

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosa Mae Duncan				2. Date of Death Month Day Year October 10, 2000		3. Time of Death 10:45pm	
	4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 240-03-2946	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 2, 1909		9. Birthplace (State or Foreign Country) North Carolina
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Middle River		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 108 Compass Road				10f. Zip Code 21220		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Thomas Ladender Lavender				18. Mother's Name (First, Middle, Maiden Surname) Donnie Dale				
19a. Informant's Name/Relationship (Type, Print) Eileen Lorenton/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Compass Road, Baltimore, MD 21220				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill		20c. Location - City or Town, State 10/14/00 Baltimore, MD		
21. Signature of Funeral Service Licensee <i>Robert J. Connelly Jr.</i>				22. Name and Address of Facility Connelly Funeral Home Of Essex 300 Mace Avenue, Baltimore, MD 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. <i>Seizures</i> Due to (or as a consequence of): b. <i>Metastatic Squamous cell cancer</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Paul A. VandeR...</i>				29c. License number DZ6835		29d. Date signed (Month, Day, Year) 10/13/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul A. VandeR... 10120 OLD NORTH POINT RD, BALTO, MD								
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature <i>Geneva D. Sparks</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32354

AMEND ITEMS: #10A-F PER INFORMANT G789 11-17-00 WR.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LUCINDA B. DREVENAK				2. Date of Death Month: OCTOBER Day: 9, Year: 2000		3. Time of Death 4:10 AM	
	4a. Facility Name (If not institution, give street and number) WILLIAMSPORT NURSING HOME				4b. City, Town, or Location of Death WILLIAMSPORT		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 220-38-1788		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min:	8. Date of Birth (Month, Day, Year) 4/6/1920	9. Birthplace (State or Foreign Country) PENNSYLVANIA
	Usual Residence of Decedent							
10a. State WV MD		10b. County BERKLEY WASHINGTON		10c. City, Town or Location WILLIAMSPORT HEDGESVILLE			10d. Inside City Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
10e. Street and Number RR 4 BOX 57 154 N. ARTIZAN ST.				10f. Zip Code 25427-9312 21795		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Collage (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) LAWRENCE P. FROSTBUTTER				18. Mother's Name (First, Middle, Maiden Surname) SUSAN DAVIS				
19a. Informant's Name/Relationship (Type, Print) ROBERT G. DREVENAK / SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22005 DICKERSON RD., DICKERSON, MD 20842				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PLEASANT VIEW MEMORY GARDENS		Date 10/13/00		20c. Location - City or Town, State MARTINSBURG, WV		
21. Signature of Funeral Service Licensee Charles M. Brown				22. Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 48 hours
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia,						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Ted Howe		29c. License number D33700		29d. Date signed (Month, Day, Year) OCTOBER 10, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TED HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature Denise B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

ADH

STEPHEN DEARBORN

00-5763-005

amend item 23a, 27 per me G788 11/1/00 amend item 12 per me 11/13/00 vf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32355

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Stephen D. Dearborn

2. Date of Death

Month Day Year
OCTOBER 8, 2000

3. Time of Death

1035 AM.

4a. Facility Name (If not institution, give street and number)

3513 SALUDA ROAD

4b. City, Town, or Location of Death

PARVILLE

4c. County of Death

BALTIMORE

5. Social Security Number

212-52-8147

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 28, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3513 Saluda Road

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Floyd W. Dearborn

18. Mother's Name (First, Middle, Maiden Surname)

Alice J. Jackman

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jayne M. Dearborn-Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3513 Saluda Road Baltimore, Maryland 21236

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp.

Date

10/12/00 Towson, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Heather Cain

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

OCTOBER 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #8 PER F.H. G788 10-24-00 WR. State of Maryland / Department of Health and Mental Hygiene 00 32356
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sally S Duffield				2. Date of Death Month 10 Day 07 Year 00				3. Time of Death 0352		
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 185-05-1931		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) 02/12/12		9. Birthplace (State or Foreign Country) PA		
	Usual Residence of Decedent				10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2825 Lodge Farm Road				10f. Zip Code 21219		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) 1 Elementary/Secondary (0-12) 0 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operator				16b. Kind of Business/Industry Security			
17. Father's Name (First, Middle, Last) Thomas Scott						18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN ELLA NORBACK SCOTT					
19a. Informant's Name/Relationship (Type, Print) Miss Adrian J. Sarah						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Eastfield Road, Baltimore, MD 21222					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Cemetery				Date 10/10/00		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee Charles Kaczorowski						22. Name and Address of Facility Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
Immediate Cause (Final disease or condition resulting in death)			a. Cardiac Tamponade Due to (or as a consequence of):						Approximate Interval Between Onset and Death 10 minutes		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			b. Aortic Aneurysm Due to (or as a consequence of):						1 week		
			c. Hypertension Due to (or as a consequence of):						50 years		
			d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular accident Recurrent falls											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Randal Briesett MD				29c. License number 20315		29d. Date signed (Month, Day, Year) 10/07/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randal Briesett MD Johns Hopkins Bayview											
31. Date filed (Month, Day, Year) OCT 13 2000			32. Registrar's Signature [Signature]								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2200

July 2, 1960

Dear Mr. [illegible]

Thank you for your letter of June 28, 1960.

Very truly,
[illegible]

(Enclosed please find)
[illegible]
[illegible]

(Enclosed please find)
[illegible]

X

X

X
X

cc: [illegible]

cc: [illegible]

cc: [illegible]

Very truly,
[illegible]

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32357

AMENDED ITEM #7 PER FH G788 10/13/00 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Ann Danielczyk				2. Date of Death Month Day Year October 11 2000		3. Time of Death 10:45 AM	
	4a. Facility Name (If not institution, give street and number) Charles Town Care Center				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 219-03-4952		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 81 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 26 1919	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10. State Maryland			
10a. State				10b. County Baltimore		10c. City, Town or Location Catonsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 707 Maiden Choice Lane				10f. Zip Code 21228		10g. Citizen of What Country? U.S. of America		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Maker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Michael Ference				18. Mother's Name (First, Middle, Maiden Surname) Rose Kuzma				
19a. Informant's Name/Relationship (Type, Print) Kenneth M. Danielczyk (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Farm Brook Ct. Perry Hall, Maryland 21128				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn		Date October 14		20c. Location - City or Town, State East Point, Md.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md. 21224				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic mesodermal CA				Due to (or as a consequence of):		Approximate Interval Between Onset and Death months		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. Due to (or as a consequence of):				
c. Due to (or as a consequence of):				d. Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 30989		29d. Date signed (Month, Day, Year) October 11 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myla M Carpenter MD 711 Maiden Choice Ln Catonsville								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32358

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Drager				2. Date of Death Month Day Year October 10 2000				3. Time of Death 6:00 P.M.		
	4a. Facility Name (If not Institution, give street and number) Augsburg Lutheran Nursing Home				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212 09 3283		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 14, 1912		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 6811 Campfield Road				10f. Zip Code 21207				10g. Citizen of What Country? U.S.			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesperson				16b. Kind of Business/Industry Singer Sewing Co.'			
17. Father's Name (First, Middle, Last) Theodore Drager				18. Mother's Name (First, Middle, Maiden Surname) Mary Schwaab							
19a. Informant's Name/Relationship (Type, Print) Mary Horst / Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Chathan Road Baltimore, Maryland 21225							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park				20c. Location - City or Town, State 10/12/00 Glen Burnie, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic heart disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier  Raymond Miller MD				29c. License number D 47683				29d. Date signed (Month, Day, Year) 10/11/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymond Miller 25 Main Street Suite 200 Parktown MD											
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32359

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Evelius				2. Date of Death Month October Day 11 Year 2000				3. Time of Death 10:30 AM	
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 202-78-8535		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 05/21/1926		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Howard		10c. City, Town or Location Ellicott City	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3233 Birchmede Drive		10f. Zip Code 21042		10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 7		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry Private Law Firm		17. Father's Name (First, Middle, Last) Charles C. Evelius		18. Mother's Name (First, Middle, Maiden Surname) Gertrude Brady		19a. Informant's Name/Relationship (Type, Print) Mary Agnes Evelius Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3233 Birchmede Drive Ellicott City, MD 21042	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Johns Cemetery		Date 10/14		20c. Location - City or Town, State Ellicott City, MD		21. Signature of Funeral Service Licensee Robert C. Lewis	
Physician /Medical Examiner	22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiomyopathy Due to (or as a consequence of): Coronary Artery Disease Atherosclerosis		Approximate Interval Between Onset and Death 3 years 20 years Unknown		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Peter Johnston, MD Resident Physician		29c. License number RES-000		29d. Date signed (Month, Day, Year) 10/11/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter Johnston, MD Doctor's Lounge Tower 110 600 N. Wolfe St. Baltimore, MD 21287	
State Registrar	31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature Beverly B. Sparks		33. Date of Death (Month, Day, Year) 10/11/00		34. Date of Birth (Month, Day, Year) 05/21/1926		35. Date of Death (Month, Day, Year) 10/11/00	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32360

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DARRYL DARNELL ENNALS		2. Date of Death Month October Day 8 Year 2000		3. Time of Death 7 AM					
	4a. Facility Name (If not institution, give street and number) STELLA MARIS AT MERCY HOSPICE		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A					
Funeral Director	5. Social Security Number 216-92-1271	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 33 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0					
	8. Date of Birth (Month, Day, Year) JULY 15, 1967		9. Birthplace (State or Foreign Country) MARYLAND							
Usual Residence of Decedent										
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY						
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 58 N. MONASTERY AVENUE		10f. Zip Code 21229		10g. Citizen of What Country? USA.						
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:						
14. Race - American Indian, Black, White, etc. Specify: BLACK										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 YEAR College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAUNDRY WORKER		16b. Kind of Business/Industry LAUNDROMAT						
17. Father's Name (First, Middle, Last) JACOB MONROE ENNALS		18. Mother's Name (First, Middle, Maiden Surname) AUDREY LOMAX								
19a. Informant's Name/Relationship (Type, Print) AUDREY ENNALS (MOTHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 N. MONASTERY AVE. BALTO. MD. 21229								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CEMETERY 10-14-00 BALTIMORE, MARYLAND		20c. Location - City or Town, State						
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Respiratory Failure Due to (or as a consequence of):</td> </tr> <tr> <td>b. Recurrent Pleural Effusion Due to (or as a consequence of):</td> </tr> <tr> <td>c. Acquired Immune Deficiency Syndrome Due to (or as a consequence of):</td> </tr> <tr> <td>d. Kaposi's Sarcoma</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory Failure Due to (or as a consequence of):	b. Recurrent Pleural Effusion Due to (or as a consequence of):	c. Acquired Immune Deficiency Syndrome Due to (or as a consequence of):	d. Kaposi's Sarcoma
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Respiratory Failure Due to (or as a consequence of):									
	b. Recurrent Pleural Effusion Due to (or as a consequence of):									
	c. Acquired Immune Deficiency Syndrome Due to (or as a consequence of):									
	d. Kaposi's Sarcoma									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M						
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 		29c. License number D37299		29d. Date signed (Month, Day, Year) October 10, 2000						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) CARLOS J. PAGE 301 ST PAUL PI BALTIMORE MD 21202										
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32361

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AUBREY

FITZGERALD

2. Date of Death

Month

Day

Year

OCTOBER 11 2000

3. Time of Death

9:35 A.M.

Funeral
Director

4e. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

U/A

5. Social Security Number

227-20-7778

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

FEB. 25, 1926

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Finksburg

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4514 LEMANS COURT

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

unk.

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Fitzgerald

19a. Informant's Name/Relationship (Type, Print)

KATHY RICE / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4514 Lemans Court Finksburg, Md 21048

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

JONES CEMETERY

Date

10-15-2000

20c. Location - City or Town, State

KENBRIDGE, Virginia

21. Signature of Funeral Service Licensee

JERRY L. LINDA

22. Name and Address of Facility

CHATHAM - HOME'S FUNERAL HOME
5240 REISTERSTOWN ROAD
BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY DISTRESS SYNDROME

24 HOURS

Due to (or as a consequence of):

b. SEPSIS

24 HOURS

Due to (or as a consequence of):

c. IDIOPATHIC THROMBOCYTOPENIC PURPURA

3 YEARS

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

JERRY L. LINDA MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

OCTOBER 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOEEN ABEDIN, M.D. 600 N. WOLFE ST. BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

JERRY L. LINDA

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32362

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Novella M. Ford

2. Date of Death

October 9 2000

3. Time of Death

11:15 am

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Cromwell Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

243-14-7763

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 6, 1914

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5410 Dewalt Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Lebo

17. Father's Name (First, Middle, Last)

O.B. Roberts

18. Mother's Name (First, Middle, Maiden Surname)

Emma Allan

19a. Informant's Name/Relationship (Type, Print)

Gerald E. Ford - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9707 Forge view Road

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mockland memorial Park 10/12/00 Parkville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Stephen All

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Road, Parkville MD 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia End stage

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

> 5 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

[Signature]

29c. License number

1541901

29d. Date signed (Month, Day, Year)

10-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zoea Mirza MD, 3076 Witten Parkway, Baltimore, MD 21214

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

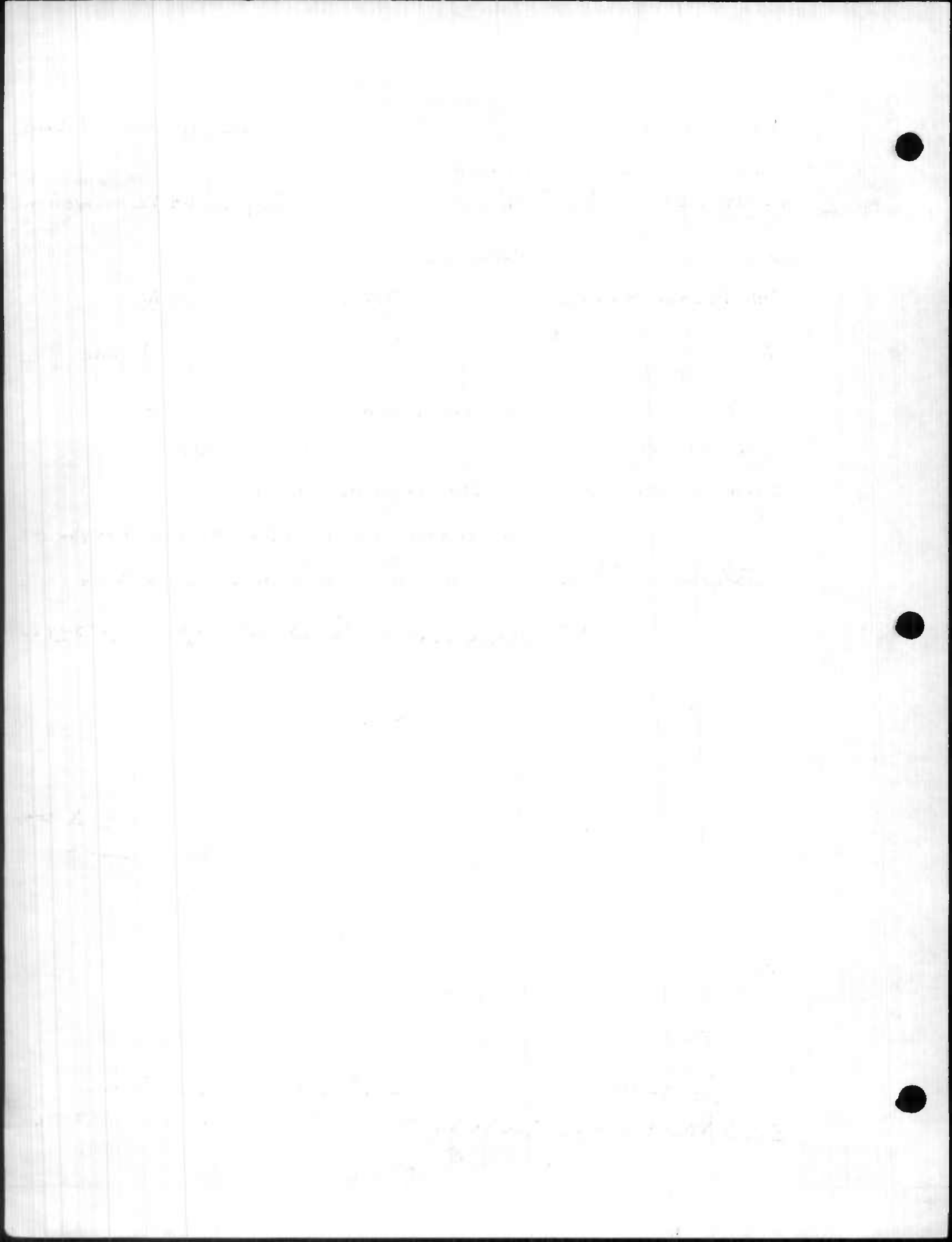
Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32363

AMEND#8 PER F.H. G789 11-15-2000 JAB

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY JANE FENWICK

2. Date of Death

Month Day Year
OCTOBER 12, 2000 4:00 am

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Fernbrook Assistive Living

4b. City, Town, or Location of Death

Odenton

4c. County of Death

Anne Arundel

5. Social Security Number

162-05-7255A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 1914
Dec. 10, 1904

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1678 Justin Drive

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Oscar A. Stillwagon

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Bray

19a. Informant's Name/Relationship (Type, Print)

William Fenwick (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1678 Justin Drive, Gambrills, MD 21054

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)
Metro Crematory

Date

10/13
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401

22. Name and Address of Facility

Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Parkinson's Disease

4 years

a. Due to (or as a consequence of):

b. Senile Dementia

6 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral Carotid Stenosis

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Living

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Harjit Singh M.D.

29c. License number

D0014160

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Harjit Singh

Baltimore, Maryland 21215-0020

pencil. Pages 1 and 2 should be filled within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

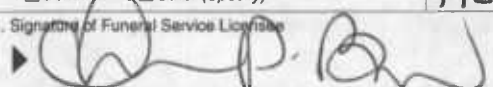

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32364

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melvin Freeman		2. Date of Death Month 10 - Day 6 - Year 00		3. Time of Death 6:30 PM
	4a. Facility Name (If not institution, give street and number) Millennium Liberty Hgts		4b. City, Town, or Location of Death BALTO MD		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-20-9504	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) JUNE 22, 1927	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County N/A	10c. City, Town or Location BALTIMORE CITY		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 4017 LIBERTY HGTS		10f. Zip Code 21207		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 yrs College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POLICE OFFICER		16b. Kind of Business/Industry POLICE DEPARTMENT		
	17. Father's Name (First, Middle, Last) JOSEPH COLLINS		18. Mother's Name (First, Middle, Maiden Summa) MARGIE FREEMAN		
	19a. Informant's Name/Relationship (Type, Print) KEITH FREEMAN (SON)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6036 CHESWORTH RD. CATONSVILLE MD 21228		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		20c. Location - City or Town, State 10-10-00 BALTIMORE, MD
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) 1 yr a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 yrs b. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. multifactor Perentia Hx of urinary bladder Carcinoma				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number D 30641		29d. Date signed (Month, Day, Year) October 10 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramesh Sabapathi 200-109 Back River Neck RD Baltimore MD 21221				
	31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32365

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Violet Johanna Germeroth				2. Date of Death Month Day Year OCTOBER 8 2000		3. Time of Death 9:18 A.M.	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-44-8292		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 79		8. Date of Birth (Month, Day, Year) 12/3/1920	
	9. Birthplace (State or Foreign Country) Rossville, MD		10a. State MD		10b. County Harford		10c. City, Town or Location Joppa	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 502 Echols Court				10f. Zip Code 21085		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry her own home	
	17. Father's Name (First, Middle, Last) John Herman Mohr				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Wilhemina Kuehne			
	19a. Informant's Name/Relationship (Type, Print) David Germeroth				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Erickson Court Joppa, Md 21085			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park Cemetery 10/11/00 Howard County		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CORONARY ATHEROSCLEROSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number D14473		29d. Date signed (Month, Day, Year) OCTOBER 10, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL TECKLENBERG, M.D. 9105 FRANKLIN SQUARE DRIVE, SUITE 106, BALTIMORE, MD 21237							
	State Registrar	31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

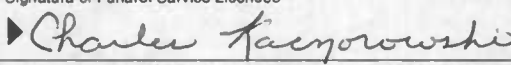
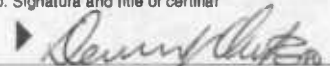

State of Maryland / Department of Health and Mental Hygiene

00 32366

DOLORES M. GAWOR

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOLORES I. GAWOR				2. Date of Death Month Day Year OCT. 8, 2000		3. Time of Death 0902 AM	
	4a. Facility Name (If not institution, give street and number) 710 SOUTH LINWOOD AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-24-4372	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/19/27		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 710 SOUTH LINWOOD AVE.				10f. Zip Code 21224		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTOMER SERVICE			16b. Kind of Business/Industry WESTVACO	
17. Father's Name (First, Middle, Last) STEPHEN F. MAKOWSKI				18. Mother's Name (First, Middle, Maiden Surname) SOPHIA BEJMA				
19a. Informant's Name/Relationship (Type, Print) MRS. NANCY JESTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 HOLLY CIRCLE BALTIMORE, MD. 21221				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. STANISLAUS CEME.		Date 10/12/00		20c. Location - City or Town, State BALTIMORE, MD.		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. 21222				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24e. Was an autopsy performed? INSPECTION <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 8, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32367

Amended Item#20b perFHG788 10/13/2000 EW

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

KAYCELE

S.

GOLDMAN

2. Date of Death

October 7, 2000

3. Time of Death

9:15PM

4a. Facility Name (If not institution, give street and number)

9813 MIDDLEMILL DRIVE

4b. City, Town, or Location of Death

OWINGS MILLS

4c. County of Death

BALTIMORE

5. Social Security Number

219-26-4963

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC.17,1934

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9813 MIDDLEMILL DRIVE

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

M. MICHAEL

GREENBERG

18. Mother's Name (First, Middle, Maiden Surname)

HILDA

KLAVERNS

19a. Informant's Name/Relationship (Type, Print)

JANICE LENGEL / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

211 CHERRY VALLEY ROAD - REISTERSTOWN, MD 21136

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HILLTOP SERVICE CORP.

Date

10/10/00

20c. Location - City or Town, State

TOWSON, MD

21. Signature of Funeral Service Licensee

Scott M. Cuthler

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardio Vascular Disease

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Ethanol Abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles F. O'Donnell MD

29c. License number

D-09383

29d. Date signed (Month, Day, Year)

October 8, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles F. O'Donnell MD

111 Hamlet Hill Rd Baltimore Maryland 21210

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Barbara E. Sparks

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32368

Amend Item 26 per phy, 788,10/13/00dhb

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Samuel D. Godwin III		2. Date of Death Month October Day 4 Year 2000		3. Time of Death 12:14 P.M.	
4a. Facility Name (If not institution, give street and number) Harbor Hospital Center			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 218 44 1456	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	8. Date of Birth (Month, Day, Year) Sept. 30, 1944	9. Birthplace (State or Foreign Country) Maryland	
Usual Residence of Decedent					
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 1319 Patapsco Avenue			10f. Zip Code 21225		10g. Citizen of What Country? U.S.
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Medical Sales	
17. Father's Name (First, Middle, Last) Samuel D. Godwin Jr.			18. Mother's Name (First, Middle, Maiden Surname) Winnifred Thompson		
19a. Informant's Name/Relationship (Type, Print) Constance Godwin			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3105 Garden Court St. Cloud, Florida 34769		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Memorial Park		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Acute Myocardial Infarction Due to (or as a consequence of):					
b. Hypertension Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D50470		29d. Date signed (Month, Day, Year) 10/6/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. ATLURI 1319 Light Street Baltimore MD 21230					
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32369

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER GEER				2. Date of Death Month OCT Day 11 Year 2000		3. Time of Death 23:46	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 242-09-3071		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) 02-18-17	
	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number 1658 E. Belvedere Avenue Apt. # 104				10f. Zip Code 21239		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry Electric Baltimore Gas &		
17. Father's Name (First, Middle, Last) James Bennett Geer				18. Mother's Name (First, Middle, Maiden Surname) Rebecca Mangum				
19a. Informant's Name/Relationship (Type, Print) Phyllis A. Geer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6910 Lachlan Circle Apt. I Baltimore, MD. 21239				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem. 10-16-2000 Arbutus, MD.		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CARDIOVASCULAR ACCIDENT Due to (or as a consequence of): c. HYPERTENSION Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier VK Gaba M.D.		29c. License number P-14184		29d. Date signed (Month, Day, Year) OCT. 11 ; 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VISAY K GABA RESIDENT; GOOD SAMARITAN HOSPITAL; BALTIMORE; MD								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

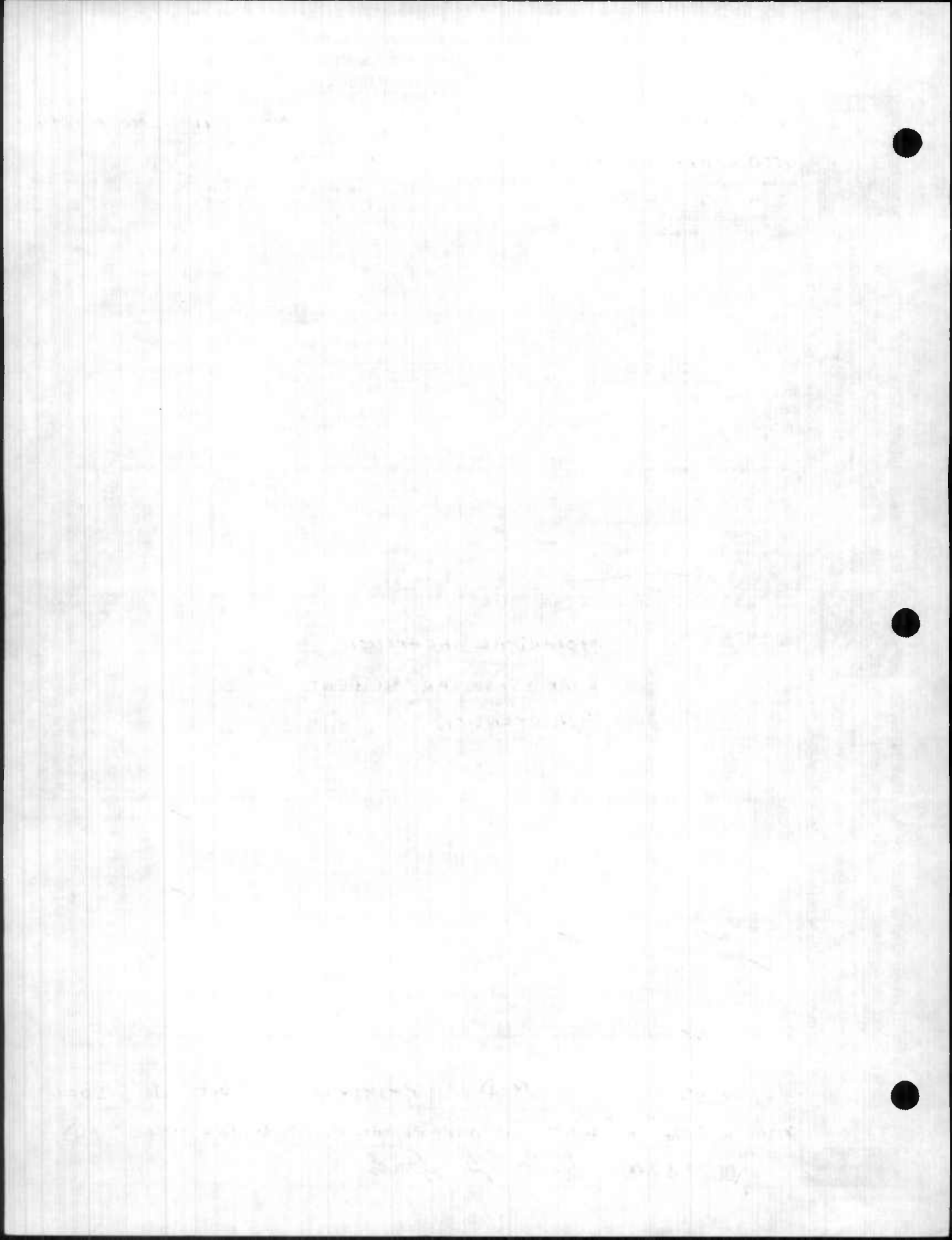
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32370

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROGER F. HAMBY					2. Date of Death Month Day Year OCTOBER 3, 2000		3. Time of Death 6:30 AM																																
	4a. Facility Name (If not institution, give street and number) Genesis Cromwell Center					4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore																																
Funeral Director	5. Social Security Number 577-44-7457		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) Apr 13, 1935		9. Birthplace (State or Foreign Country) DC																															
	Usual Residence of Decedent																																							
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																
	10e. Street and Number 8710 Emge Road				10f. Zip Code 21234		10g. Citizen of What Country? USA																																	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: '52-54		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white																																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) sales			16b. Kind of Business/Industry retail																																
	17. Father's Name (First, Middle, Last) Jesse L. Hamby					18. Mother's Name (First, Middle, Maiden Surname) Ethel G. Johnson																																		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Clara Hamby/spouse					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 E. Joppa Rd # 212 Towson, MD 21286																																		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State																																
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director					22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201																																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																							
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><i>Cerebral Vascular Accident</i></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4"><i>days</i></td> </tr> <tr> <td>b.</td> <td><i>CVA</i></td> </tr> <tr> <td>c.</td> <td><i>Dementia</i></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	<i>Cerebral Vascular Accident</i>	Due to (or as a consequence of):	<i>days</i>	b.	<i>CVA</i>	c.	<i>Dementia</i>	d.																				
Immediate Cause (Final disease or condition resulting in death)	a.	<i>Cerebral Vascular Accident</i>	Due to (or as a consequence of):	<i>days</i>																																				
	b.	<i>CVA</i>																																						
	c.	<i>Dementia</i>																																						
	d.																																							
<table border="0"> <tr> <td colspan="5">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>GERD HTN Depression Psychosis</i></td> <td colspan="5">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="5"></td> <td colspan="5">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> <tr> <td colspan="5"></td> <td colspan="5">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>										Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>GERD HTN Depression Psychosis</i>					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>GERD HTN Depression Psychosis</i>					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																																			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																			
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																			
<table border="0"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="8">26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="3">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="2"></td> <td colspan="5">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="3">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>										25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)																																	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																								
29b. Signature and title of certifier <i>Martha Raymond MD</i>					29c. License number 054518			29d. Date signed (Month, Day, Year) 10-6-00																																
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 3007-E Northern Parkway Baltimore MD 21214 MARTHA RAYMOND																																								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature <i>Sparks</i>																																						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32371

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALLEN HARTWELL SR.			2. Date of Death Month Day Year OCTOBER 05, 2000		3. Time of Death 8:00 AM	
	4a. Facility Name (If not institution, give street and number) 518 NORTH CALHOUN STREET			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 251-44-5633		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 20, 1931
	9. Birthplace (State or Foreign Country) SOUTH CAROLINA		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 518 NORTH CALHOUN STREET		10f. Zip Code 21223		10g. Citizen of What Country? USA.
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH GRADE College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSTRUCTION WORKER POTTS & CALLAHAN		16b. Kind of Business/Industry		
	17. Father's Name (First, Middle, Last) JOE HARTWELL		18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH MOULTRIE				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) RETHA HARTWELL (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2203 W. SARATOGA ST. BALTO. MD. 21223				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ARBUTUS CEMETERY		20c. Location - City or Town, State BALTIMORE, MARYLAND		20d. Date 10-12-00
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Provider 		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE MD. 21217				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Due to (or as a consequence of): Coronary artery disease Due to (or as a consequence of): Atherosclerosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier CD Kearney MD		29c. License number D002786		29d. Date signed (Month, Day, Year) October 10th, 2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOPHER D. KEARNEY MD 700 WASH. BLD. BALT. MD. 21230		31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 		

ORIGINAL

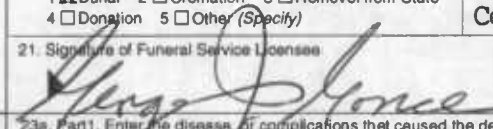
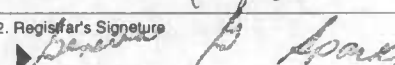
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32372

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED HOWARD				2. Date of Death Month Day Year October 10 / 2000		3. Time of Death 3:15 AM	
	4a. Facility Name (If not institution, give street and number) Harbor Hospital Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 220 18 7700		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 18, 1917	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10a. Street and Number 1429 Woodall Street		10f. Zip Code 21230		10g. Citizen of What Country? U.S.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator		16b. Kind of Business/Industry McCormick and Co.				
17. Father's Name (First, Middle, Last) John Herzberger				18. Mother's Name (First, Middle, Maiden Surname) Eva Ray				
19a. Informant's Name/Relationship (Type, Print) William Howard Jr. / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Shipley Road Linthicum, Maryland 21090				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 10/9/00 Baltimore, Maryland				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmias Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Congestive Heart Failure Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1 day						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier K. Atluri				29c. License number P14435		29d. Date signed (Month, Day, Year) October 5th 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KALPANA ATLURI, Resident physician at Harbor Hospital center, Baltimore, MD - 21225.								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32373

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joan K. Hall		2. Date of Death Month Day Year OCTOBER 12 2000		3. Time of Death 1306
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 217-50-0234	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) April 23, 1947		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 2808 Huntingdon Avenue			10f. Zip Code 21211		10g. Citizen of What Country? USA
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Manufacturing	
17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (First, Middle, Maiden Surname) Helen Satterwhite		
19a. Informant's Name/Relationship (Type, Print) George Hall (Husband)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2808 Huntingdon Avenue, Baltimore, MD 21211		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory		20c. Location - City or Town, State Balto-Washington 10/13/00 Laurel, Maryland	
21. Signature of Funeral Service Licensee Lynn B. Henss		22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland 21211			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. renal obstruction		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. metastatic colon cancer		Due to (or as a consequence of):	
		c.		Due to (or as a consequence of):	
		d.		Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier W. Henss		29c. License number AT2438946		29d. Date signed (Month, Day, Year) 10/12/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KRISTIN ROBERTS MD 201 E. UNIVERSITY PKWY BALTIMORE, MD 21218					
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature B Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32374

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marvin L. Ingram		2. Date of Death Month Day Year October 9 2000		3. Time of Death 10:15 am
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital		4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel
Funeral Director	5. Social Security Number 226-28-2886	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Oct. 6, 1924		9. Birthplace (State or Foreign Country) Virginia		
Usual Residence of Decedent					
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Millersville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 1116 Indian Landing		10f. Zip Code 21108		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Grocery	
17. Father's Name (First, Middle, Last) Meshaeh Ingram		18. Mother's Name (First, Middle, Maiden Surname) Clemence Carter			
19a. Informant's Name/Relationship (Type, Print) Lillian M. Ingram (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1116 Indian Landing, Millersville, MD 21108			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Our Lady of the Fields		20c. Location - City or Town, State 10/13 2000 Millersville, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Lung Cancer			Approximate Interval Between Onset and Death 2 mos.
		Due to (or as a consequence of):			
		b. Cardiopulmonary Arrest			1 day
		Due to (or as a consequence of):			
		c. Lung Cancer			
		Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number 031551		29d. Date signed (Month, Day, Year) October 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell R. Deluca no 1600 S Crain Highway, Glen Burnie, MD 21061					
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32375

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Blanche L. Vearns

2. Date of Death

Month Day Year
OCTOBER 10, 2000

Day

Year

3. Time of Death

3:00 PM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

213-03-3688

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 18, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8820 Walther Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert E. Hunt

18. Mother's Name (First, Middle, Maiden Surname)

Otto Bell

19a. Informant's Name/Relationship (Type, Print)

Sharon Miller - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Hapsburg Court, Parkville, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)Evans Funeral Chapel -
Belair, P.A.

Date

10/12/00

20c. Location - City or Town, State

Belair, Maryland

21. Signature of Funeral Service Licensee

Stephen A. Bell

22. Name and Address of Facility

Evans Funeral Chapel
8800 Hartford Road, Parkville MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PNEUMONIA

Approximate
Interval Between
Onset and Death

4 DAYS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

SIDEROBLASTIC ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Beatriz P. Dizon, M.D.

29c. License number

D0016492

29d. Date signed (Month, Day, Year)

October 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEATRIZ P. DIZON, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32376

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert S. Kline, Jr.

2. Date of Death

October 12 2000

3. Time of Death

5:55pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

216-10-6398

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 6, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2804 Chenook Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

fire controlman

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Marvin H. Kline

18. Mother's Name (First, Middle, Maiden Surname)

Anne Catherine Kennady

19a. Informant's Name/Relationship (Type, Print)

Robert S. Kline, Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2814 Chenook Ave. Baltimore, Md 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Ceme.

Date

Oct 17 2000

20c. Location - City or Town, State

Parkville Md

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Funeral Chapel
8800 Harford Rd. Baltimore, Md 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Multi-organ system failure

Due to (or as a consequence of):

c. Acute Renal failure

Due to (or as a consequence of):

d. Hepatic failure

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Dr. Giuseppe Esposito

29c. License number

RD203265

29d. Date signed (Month, Day, Year)

10-12-00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

DR Giuseppe Esposito 9000 Franklin Square Drive Baltimore MD 21237

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

Kline, Robert
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32377

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SANDRA L. KAMMER

2. Date of Death

Month

Day

Year

Oct. 12 2000

3. Time of Death

6:05 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

2702 LINWOOD AVE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

216-84-2575

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 25, 1960

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md

10b. County

—

10c. City, Town or Location

BALTIMORE, Md.

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2702 LINWOOD AVE

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

—

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

OFFICE MANAGER

16b. Kind of Business/Industry

York Rd Doctors

17. Father's Name (First, Middle, Last)

JOSEPH BRAMBLE

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE SEWELL

19a. Informant's Name/Relationship (Type, Print)

BRIAN W. KAMMER / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2702 LINWOOD AV. BALTO MD 21224

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

GREENMOUNT CREM.

Date

10/16/00

20c. Location - City or Town, State

BALTO MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME, CHT
7527 HARFORD RD. BALTO MD 2123423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Liver failure

Due to (or as a consequence of):

~ 2 weeks

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Metastatic esophageal adenocarcinoma

Due to (or as a consequence of):

~ 18 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?
☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D16587

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Chang, MD 5601 Loch Raven Blvd, Ste 107, Baltimore, MD 21239

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32378

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWIN VERNON KEIM				2. Date of Death Month Day Year OCTOBER 5, 2000		3. Time of Death 1:10 AM	
	4a. Facility Name (If not institution, give street and number) 2658 BALDWIN MILL ROAD				4b. City, Town, or Location of Death BALDWIN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-18-1521		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth Month Day Year 3/26/24	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County BALTIMORE		10c. City, Town or Location BALDWIN	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 2658 BALDWIN MILL ROAD		10f. Zip Code 21013	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED				16b. Kind of Business/Industry OIL COMPANY			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) LOUIS KEIM				18. Mother's Name (First, Middle, Maiden Surname) KATHERINE HEYMAN			
	19a. Informant's Name/Relationship (Type, Print) MRS. MARGARET KEIM				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2658 BALDWIN MILL RD. BALDWIN, MD. 21013			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CEME.		20c. Location - City or Town, State BALTIMORE, MD.	
	21. Signature of Funeral Service Licensee Charles Kaczorowski				22. Name and Address of Facility KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Bacterial sepsis Due to (or as a consequence of): b. Septic vascular disease Due to (or as a consequence of): c. Diabetic mellitus Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 7 days 6 months 20 years			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate cancer Cognitive heart failure CVA				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, a/c. (Specify)	
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier [Signature]				29c. License number 015329		29d. Date signed (Month, Day, Year) 10/5/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JAMES H. MURPHY MD, 6565 N. CHARLES ST. SUITE 411, BALT, MD 21204				31. Date filed (Month, Day, Year) OCT 13 2000			
	32. Registrar's Signature [Signature]				33. Registrar's Title [Signature]			

ORIGINAL

Section 1
Lumber
Barn

1000
1000
1000

1000

1000

1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32379

AMEND ITEM: 20C PER F.H. G788 10-16-00 WR.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bennie Knight

2. Date of Death
Month Day Year
OCTOBER 11 20003. Time of Death
2048

4a. Facility Name (If not institution, give street and number)

SINAL HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral
Director

5. Social Security Number

216-54-8073

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
08-05-48

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

3214 Avon Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

High School

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Various Trades

16b. Kind of Business/Industry

in & out home

17. Father's Name (First, Middle, Last)

Benjamin Bassett Knight

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Pindell

19a. Informant's Name/Relationship (Type, Print)

Pauline Knight

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3214 Avon Avenue Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery 10-16-2000 Baltimore, MD

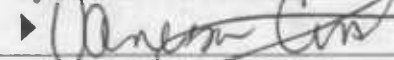
Data

10-17-00

20c. Location - City or Town, State

LANSDOWN MD.

21. Signature of Funeral Service Licentiate



22. Name and Address of Facility

Baltimore, Maryland 21202
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Due to (or as a consequence of):

HIV

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

10 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

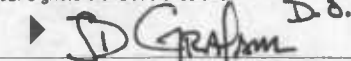
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

RES 0000

29d. Date signed (Month, Day, Year)

OCTOBER 11 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

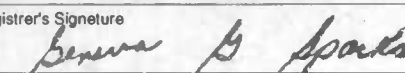
JEREMY GRAHAM D.O. 2401 WEST BELVEDERE AVENUE BALTIMORE, MD 21215

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature



Knight, Bennie

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1941

1941

1941

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Certificate of Death

Reg. No.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

1. Decedent's Name (First, Middle, Last) <u>Herman Letke</u>		2. Date of Death Month <u>October</u> Day <u>12</u> Year <u>2000</u>		3. Time of Death <u>0625</u>	
4a. Facility Name (If not institution, give street and number) <u>Ivy Hall Genatric</u>		4b. City, Town, or Location of Death <u>Middle River</u>		4c. County of Death <u>Baltimore</u>	
5. Social Security Number <u>213-09-3224</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>96</u> Yrs.	
8. Date of Birth (Month, Day, Year) <u>March 22, 1904</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>			
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Essex</u>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>618 Eastern Avenue</u>		10f. Zip Code <u>21221</u>	
10g. Citizen of What Country? <u>USA</u>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) <u>8</u> Elementary/Secondary (0-12) <u>8</u> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Foreman</u>		16b. Kind of Business/Industry <u>Bethlehem Steel</u>	
17. Father's Name (First, Middle, Last) <u>Theodore Letke</u>		18. Mother's Name (First, Middle, Maiden Summa) <u>Mary Fisher</u>			
19a. Informant's Name/Relationship (Type, Print) <u>Dave Letke/Son</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>618 Eastern Avenue, Baltimore, MD 21221</u>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holly Hill</u>		20c. Location - City or Town, State <u>10/14/00 Baltimore, Maryland</u>	
21. Signature of Funeral Service Licensee <u>Robert J. Connelly</u>		22. Name and Address of Facility <u>Connelly Funeral Home Of Essex</u> <u>300 Mace Avenue Baltimore, Maryland 21221</u>			
23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Ischemic Cardiomyopathy</u> Due to (or as a consequence of): <u>Myocardial Infarction</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Renal failure, Pneumonia, atrial fibrillation</u>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		Approximate Interval Between Onset and Death <u>2 days</u> <u>2 days</u>	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury <u>M</u> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>M. D.</u>		29c. License number <u>D-38754</u>	
29d. Date signed (Month, Day, Year) <u>10-12-2000</u>		30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>MALIKA WASEEM. 709. EASTERN BLVD. MD - 21221.</u>			
31. Date filed (Month, Day, Year) <u>OCT 13 2000</u>		32. Registrar's Signature <u>B. Smith</u>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32381

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jose Martinez, M.D.

2. Date of Death

October 10 2000 10:10 PM

3. Time of Death

Funeral
Director

4e. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

219-40-4714

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 9, 1930

9. Birthplace (State or Foreign Country)

Egypt

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8810 Walther Blvd.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Spain

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Doctor

16b. Kind of Business/Industry

Self employed

17. Father's Name (First, Middle, Last)

Francisco

Martinez

18. Mother's Name (First, Middle, Maiden Surname)

Kalphadeli

19a. Informant's Name/Relationship (Type, Print)

Mr. Patrick G. Martinez/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Sawgrass Ct. Timonium, Md. 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial

Date

10/12/00

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra Cranial Hemorrhage

Due to (or as a consequence of):

b. Hypertension and Caudal

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Lavanja Varlagadda

29c. License number

RD 203406

29d. Date signed (Month, Day, Year)

10/10/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Lavanja Varlagadda 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

[Signature]

State Registrar

ORIGINAL

MAR TINEZ Jose
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

W. H. H. H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32382

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH MILLER

2. Date of Death

Month Day Year
OCTOBER 5, 2000

3. Time of Death

3:27 PM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice Timonium

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

215-18-5769

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

103 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 23, 1897

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Parkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2327 Mt. Carmel Road

10f. Zip Code

21120

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: white15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

school teacher

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

Benjamin G. Miller

18. Mother's Name (First, Middle, Maiden Surname)

Cora Stockdale

19a. Informant's Name/Relationship (Type, Print)

Benjamin Miller/nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2327 Mt. Carmel Road Parkton, MD 21120

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

10/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

[Signature]

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

OCTOBER 5, 2000 3:23 p.m.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RUTH MILLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32383

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

SALLY T. MOHR

2. Date of Death

September 30, 2000

3. Time of Death

7:00 PM

Funeral
Director

4e. Facility Name (If not institution, give street and number)

FOREST GLEN NURSING HOME

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

227-18-1820

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 5, 1915

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10e. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2700 Barker Street

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

nursing asst

16b. Kind of Business/Industry

health

17. Father's Name (First, Middle, Last)

Thomas Canada

18. Mother's Name (First, Middle, Maiden Surname)

Rosa

19a. Informant's Name/Relationship (Type, Print)

unk

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unk

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cancer Breast with Metastasis.

PEG Feeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

RAMAN R. TULI, MD

29c. License number

D19609

29d. Date signed (Month, Day, Year)

10-6-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAMAN R. TULI 3503 PERRY STREET. MOUNT RAINIER, MD 20712

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Raman R. Tuli

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32384

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sheila Ann Martin				2. Date of Death Month Day Year October 09 2000		3. Time of Death 09:24 A.M.	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 214-68-4422		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) 1-10-1956	
	10a. State Md		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 2724 Parkwood Avenue				10f. Zip Code 21217		10g. Citizen of What Country? U S A		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) 1 Year				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) Powell Martin				18. Mother's Name (First, Middle, Maiden Surname) Ethel Oliver				
19a. Informant's Name/Relationship (Type, Print) Ethel Martin -Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2724 Parwood Avenue Baltimore, Md 21217				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 10-14-00 Randallstown, Md		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Pulmonary thromboembolism due to deep Due to (or as a consequence of): venous thrombosis of lower extremities b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 10, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz				111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature <i>[Signature]</i>				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32385

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>STELLA</i>		2. Date of Death Month <i>OCTOBER</i> Day <i>06</i> Year <i>2000</i>		3. Time of Death <i>10:35AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE</i>		4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>172-18-7365</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>82</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Oct. 21, 1917</i>
	9. Birthplace (State or Foreign Country) <i>Pennsylvania</i>					
To Be Completed by Funeral Director	Usual Residence of Decedent		10e. State <i>Maryland</i>		10b. County <i>N/A</i>	
	10c. City, Town or Location <i>Baltimore City</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <i>3132 O'Donnell Street</i>		10f. Zip Code <i>21224</i>		10g. Citizen of What Country? <i>United States</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8 Years</i>		College (1-4or 5+) <i>College</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>	
	16b. Kind of Business/Industry <i>Own Home</i>					
	17. Father's Name (First, Middle, Last) <i>Zachary Nebesney</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Margaret Lucyvcv</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Dolores Misterka (Daughter)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3132 O'Donnell Str. Baltimore, Maryland 21224</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>St. Stanislaus Cem.</i>		20c. Location - City or Town, State <i>10/10/2000 Baltimore, Maryland</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</i>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>HEPATIC CIRRHOSIS</i> Due to (or as a consequence of): <i>HEPATIC FAILURE</i> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					Approximate Interval Between Onset and Death <i>YEARS</i> <i>2 WEEK</i>
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>DISSEMINATED INTRAVASCULAR COAGULATION</i>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>21010</i>	29d. Date signed (Month, Day, Year) <i>OCTOBER 11, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>EVE LYN MENTARE MD 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224</i>						
31. Date filed (Month, Day, Year) <i>OCT 13 2000</i>		32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32386

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian V. Mallonee

2. Date of Death

Month Day Year
October 12 2000

3. Time of Death

4:30 A.M.

4a. Facility Name (If not institution, give street and number)

Anne Arundel General Hospital

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

212 34 8450

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
August 22, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

182 Severn Way

10f. Zip Code

21012

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Lample

18. Mother's Name (First, Middle, Maiden Surname)

Rosa Eizenhood

19a. Informant's Name/Relationship (Type, Print)

John Mallonee / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

182 Severn Way Arnold, Maryland 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

10/12/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.

4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

12^h

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE CHOLECYSTITIS

Due to (or as a consequence of):

4/8-72^h

c. PERITONITIS

Due to (or as a consequence of):

48-72^h

d. CHRONIC GASTRITIS/LOW GRADE GI BLEED

4-6 m

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia of chronic disease, atrial fibrillation

congestive heart failure, tubulovillous

adenoma & partial colectomy 1998; periph. neuropathy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31997

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW GORDON MD 2003 Medical Pkwy Ste 100 Annapolis, Md 21401

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Benjamin A. Sparks

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32387

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

George Mercer

2. Date of Death

Month Day Year
Oct. 11, 2000

3. Time of Death

12:01pm

4a. Facility Name (If not institution, give street and number)

Future Care Nursing Home

4b. City, Town, or Location of Death

Severna Park

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

237-46-2306

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 13, 1930

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

106 Manns Rd

10f. Zip Code

21146

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify Afro American

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

Collega (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Tommie Mercer

18. Mother's Name (First, Middle, Maiden Surname)

Bloomer Taylor

19a. Informant's Name/Relationship (Type, Print)

Bernice Mercer/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Manns RD Glen Burnie, MD 21146

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Green Mount Cemetery Oct 18, 2000 Balto., MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO. MD 21213

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. End stage Renal disease

Approximate
Interval Between
Onset and Death

2 week

Due to (or as a consequence of):

b. Coronary artery disease

many years

Due to (or as a consequence of):

c. Hypertension

many years

Due to (or as a consequence of):

d. Non Insulin Dependent Diabetes Mellitus

Many years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature] MD

29c. License number

D40519

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIRZA M. NUSQAREE 7845 Oakwood Proj, bldg, Glen Burnie, 21061

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

[Signature] Sparks

State
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32388

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) CLIFFORD AVON MILHOUS		2. Date of Death Month Day Year October 06, 2000		3. Time of Death 11:05 A.M.	
4a. Facility Name (If not institution, give street and number) 611 E Cherry Crest Road			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
5. Social Security Number 216-58-2326	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 17, 1952
9. Birthplace (State or Foreign Country) Maryland					
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 611 E CHERRY CREST ROAD		10f. Zip Code 21225	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STEEL WORKER		16b. Kind of Business/Industry BETHLEHEM STEEL		17. Father's Name (First, Middle, Last) JOSEPH MILHOUS	
18. Mother's Name (First, Middle, Maiden Surname) ALAN JOHNSON		19a. Informant's Name/Relationship (Type, Print) JOANN MILHOUS / SISTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3516 LADYMINTH ROAD Apt. A1 Baltimore, Maryland	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY		20c. Location - City or Town, State Baltimore, Maryland	
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility CHATHAM - HARRIS FUNERAL HOME 5240 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. FATTY LIVER Due to (or as a consequence of): b. CHRONIC ALCOHOLISM Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 07, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32389

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Isabell C. Norton

2. Date of Death

October 11, 2000

3. Time of Death

7:55 P.M.

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Keswick Multi Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

213-46-0983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

November 25, 1908

9. Birthplace (State or Foreign Country)

Milwaukee, Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

202 Eastridge Garth

10f. Zip Code

21093

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

n/a

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Winfield O'Connell

18. Mother's Name (First, Middle, Maiden Surname)

Louise Cetner

19a. Informant's Name/Relationship (Type, Print)

Mrs. Karen A. Beckhardt (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

233 East Timonium Road Timonium, Maryland 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Ramsey Cemetery

Date

10/16/2000

20c. Location - City or Town, State

Ramsey, (Fayette Co.) Ill.

21. Signature of Funeral Service Licensee

Jeffrey L. Gair

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.
1050 York Rd. Towson, Md. 21204-251523a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. CONGESTIVE HEART FAILURE

Approximate
Interval Between
Onset and Death

72h

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jeffrey L. Gair

29c. License number

D30433

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GSMC 6701 N CHARLES ST

BALTIMORE

MD 21204

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

James P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32390

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Zenab Naquib		2. Date of Death Month 10 Day 12 Year 2000		3. Time of Death 9:45 a.m.	
4a. Facility Name (If not institution, give street and number) St Joseph Hospital			4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore
5. Social Security Number 081-82-0214		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	8. Date of Birth (Month, Day, Year) 6-26-1924	9. Birthplace (State or Foreign Country) Egypt
Usual Residence of Decedent					
10a. State Md		10b. County Balto		10c. City, Town or Location Cockeysville	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 10591 Topsfield Drive			10f. Zip Code 21030		10g. Citizen of What Country? Egypt
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) Aly Naguib			18. Mother's Name (First, Middle, Maiden Surname) Turk		
19a. Informant's Name/Relationship (Type, Print) Salem Wahby -Son-In-Law			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10591 Topsfield Drive Cockeysville, Md 21030		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		20c. Location - City or Town, State 10-13-00 Randallstown, Md	
21. Signature of Funeral Service Licensee March		22. Name and Address of Facility March Funeral Home west 4300 Wabash Ave.			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. Acute MI Due to (or as a consequence of): 1-2 hours					
b. 4/2 Parkinson's Disease Due to (or as a consequence of): 5+ years					
c. 4/2 Cervical Spinal Cord Lesions Due to (or as a consequence of): 10+ yrs.					
d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]			29c. License number D14221		29d. Date signed (Month, Day, Year) 10.12.2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. A. Filozov up 223 BASTARD BLVD BALT MD 21221					
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#7 per FHG788 10/13/2000 EW

Certificate of Death

Reg. No. 00 32391

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANK NIEMAN				2. Date of Death Month: OCTOBER Day: 12 Year: 2000		3. Time of Death 7:30 A.M.	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER				4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 202-10-6440	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) Nov. 12, 1920		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3 Paula Place- Apt. 2C				10f. Zip Code 21237		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 145		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Carpentry		
17. Father's Name (First, Middle, Last) John Nieman				18. Mother's Name (First, Middle, Maiden Surname) Eva Kada				
19a. Informant's Name/Relationship (Type, Print) Zola M. Nieman- Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Paula Place- Apt. 2C Baltimore, Maryland 21237				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem.		20c. Date 10/14/00		20d. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee Heather Cain				22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION Due to (or as a consequence of): b. PARKINSON'S DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SHY DRAGER'S SYNDROME ASBESTOSIS						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of Certifier [Signature]				29c. License number D 31076		29d. Date signed (Month, Day, Year)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORN ELIASSON, MD, 6830 HOSPITAL DRIVE, BALTIMORE, MD 21237								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32392

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Charles B. O'Neil</u>				2. Date of Death Month Day Year <u>OCTOBER 12 2000</u>		3. Time of Death <u>6:00 A.M.</u>	
	4a. Facility Name (If not institution, give street and number) <u>FRANKLIN SQUARE HOSPITAL CENTER</u>				4b. City, Town, or Location of Death <u>ROSEDALE</u>		4c. County of Death <u>BALTIMORE</u>	
Funeral Director	5. Social Security Number <u>218-60-7307</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>46</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Aug. 12, 1954</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Md</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Parkville</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <u>2 Forgotten Ct.</u>		10f. Zip Code <u>21234</u>	
	10g. Citizen of What Country? <u>USA</u>				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>-</u>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Chef</u>				16b. Kind of Business/Industry <u>restaurant</u>		17. Father's Name (First, Middle, Last) <u>FRANK C. O'Neil</u>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Lee</u>				19a. Informant's Name/Relationship (Type, Print) <u>Marylee O'Neil</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2 Forgotten Ct. Baltimore, Md 21234</u>	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Gardens of Faith</u>		20c. Location - City or Town, State <u>Rosedale, Md</u>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>Heidi S. Wells</u>				22. Name and Address of Facility <u>Evans Funeral Chapel</u> <u>8800 Harford Rd. Baltimore, Md 21234</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>CIRRHOSIS OF LIVER</u> Due to (or as a consequence of): b. <u>HEPATITIS C</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) <u>Oct 12 2000</u>				28b. Time of Injury <u>M</u>			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>Stuart Willes MD</u>			
	29c. License number <u>D36663</u>				29d. Date signed (Month, Day, Year) <u>OCTOBER 12, 2000</u>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>STUART WILLES, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237</u>							
	31. Date filed (Month, Day, Year) <u>OCT 13 2000</u>				32. Registrar's Signature <u>[Signature]</u>			

ORIGINAL

00-5283-510
Donald Pennington
mmmr

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

00 32393

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald Pennington		2. Date of Death Month Day Year September 18, 2000		3. Time of Death 1605 pm	
	4a. Facility Name (If not Institution, give street and number) 2525 North Eutaw Place, Apartment #607		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number unk		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.	
	8. Date of Birth (Month, Day, Year) Apr 3, 1930		9. Birthplace (State or Foreign Country) unk			
Usual Residence of Decedent						
10a. State MD		10b. County		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2525 N. Eutaw Place #607			10f. Zip Code 21217		10g. Citizen of What Country? USA	
11. Marital Status unk <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? unk <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk			18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk	
17. Father's Name (First, Middle, Last) unk			18. Mother's Name (First, Middle, Maiden Surname) unk			
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state			20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director			22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Human Immunodeficiency Virus Infection, Pulmonary Thromboembolism					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier Thodore M. King, Jr.			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thodore M. King 111 Penn Street, Baltimore, Maryland 21201						
State Registrar		31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature Benjamin S. Sparks		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32394

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) JOHN PERRY		2. Date of Death Month Day Year SEPTEMBER 23 2000		3. Time of Death 11:00 A
4a. Facility Name (If not institution, give street and number) 1812 W. PRATT ST.		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
5. Social Security Number UNK	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. unk	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) unk		9. Birthplace (State or Foreign Country) unk		
Usual Residence of Decedent				
10a. State MD	10b. County	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
10e. Street and Number 1812 W. Pratt Street		10f. Zip Code 21223		10g. Citizen of What Country? USA
11. Marital Status unk 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? unk 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk		
17. Father's Name (First, Middle, Last) unk		18. Mother's Name (First, Middle, Maiden Surname) unk		
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier J. M. TIVS		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPTEMBER 24, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TIVS, M.D. 111 Penn Street, Baltimore, Maryland 21201				
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature B. Sparks		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32395

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy

Peterson

2. Date of Death

Month Day Year
OCTOBER 12 2000

3. Time of Death

7:28 am

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

216-05-6778

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

Nov. 26, 1909

9. Birthplace (State or Foreign
Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

700 West 40th Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Dietary worker

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Louis J. Nagle

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Carroll

19a. Informant's Name/Relationship (Type, Print)

George W. McManus- attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3703 Greenway, Baltimore, MD 21218

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hilltop Service Corporation

Date

10/16/00

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

William G. Dau

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.
5305 Harford Rd., Baltimore, MD 2121423a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Sepsis

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

24 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Myocardial infarction

Due to (or as a consequence of):

24 hrs

c. ATRIAL Arrhythmias

Due to (or as a consequence of):

24 hrs

d. Anemia

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined28a. Date of injury
(Month, Day Year)28b. Time of
injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

John W. Bowie MD

29c. License number

D20649

29d. Date signed (Month, Day, Year)

10/12/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John W. Bowie 6701 N. Charles St. Towson MD 21204

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

B. Spaul

State
Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32396

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES FRANKLIN PARKS				2. Date of Death Month Day Year OCTOBER 09 2000				3. Time of Death 0705			
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN				4c. County of Death WASHINGTON			
Funeral Director	5. Social Security Number 232-90-3328		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) 9/16/1954		9. Birthplace (State or Foreign Country) WEST VIRGINIA			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State WV		10b. County BERKELEY		10c. City, Town or Location MARTINSBURG				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 220 PINE COURT				10f. Zip Code 25401		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LAB TECHNICIAN			16b. Kind of Business/Industry RUST-OLEUM CORP.				
	17. Father's Name (First, Middle, Last) CHARLES RAYMOND PARKS				18. Mother's Name (First, Middle, Maiden Surname) BERNICE ELIZABETH GRANTHAM							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CHARLES RAYMOND PARKS / FATHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 JOHNSON ST., MARTINSBURG, WV 25401							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. HOPE CEMETERY		Date 10/14/00		20c. Location - City or Town, State MARTINSBURG, WV					
	21. Signature of Funeral Service Licensee Charles M. Brown				22. Name and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RIGHT VENTRICULAR DYSPLASIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier Theodore M. King				29c. License number O.C.M.E			29d. Date signed (Month, Day, Year) OCTOBER 10, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature S. Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32397

Amend Item 1 per phy,788,10/13/00dhb

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Fannie B. Pusinsky</u>		2. Date of Death Month <u>10</u> Day <u>05</u> Year <u>2000</u>		3. Time of Death <u>1403</u>
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>234 309399</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>77</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>5/19/23</u>		9. Birthplace (State or Foreign Country) <u>West Virginia</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <u>914 South Carey Street</u>			10f. Zip Code <u>21223</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5</u> College (1-4or 5+) <u>0</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Homemaker</u>		16b. Kind of Business/Industry <u>Own Home</u>
17. Father's Name (First, Middle, Last) <u>(unobtainable) Napier</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Libby Burns</u>		
19a. Informant's Name/Relationship (Type, Print) <u>Libby Pusinsky-Daughter</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>119 Glider Drive Middle River, MD 21220</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Baltimore Washington Cr.</u>		20c. Location - City or Town, State <u>10-11-00 Laurel, Maryland</u>	
21. Signature of Funeral Service Licensee <u>Mark Marshall</u>		22. Name and Address of Facility <u>Gary L. Kaufman Funeral Home</u> <u>7250 Washington Blvd. Elkridge, Maryland 21075</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Ischemic Bowel</u> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <u>7 Days</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <u>Arrhythmia</u> Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>James L. Univ. MD Med. CTR.</u>		29c. License number <u>P14730</u>		29d. Date signed (Month, Day, Year) <u>10/5/00</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>22 South Green St. Baltimore, Maryland 21201</u>					
31. Date filed (Month, Day, Year) <u>OCT 13 2000</u>		32. Registrar's Signature <u>Benita B. Sparks</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32398

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CATHARINE PATRO

2. Date of Death

Month 10 Day 6 Year 2000

3. Time of Death

9:45 AM

Funeral
Director

4a. Facility Name (If not Institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE, MD

4c. County of Death

BALTIMORE CITY

5. Social Security Number

217-12-7915

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

07/30/1924

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2219 Fleet Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Caucasian

15. Decedent's Education
(Specify only highest grade completed)

9 Elementary/Secondary (0-12)

0 College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Henry Coyne

18. Mother's Name (First, Middle, Maiden Summa)

Katie Weber

19a. Informant's Name/Relationship (Type, Print)

Mr. Edward Patro

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4905 Tartan Hill Road, Baltimore, MD 21128

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify): Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Stanislaus

Date

10/11/00 Baltimore, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Charles Kaczorowski

22. Name and Address of Facility

Kaczorowski Funeral Home, P.A.

1201 Dundalk Avenue, Baltimore, MD 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

45 MINUTES

Due to (or as a consequence of):

b. MYOCARDIAL INFARCTION

45 MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Melanie R

29c. License number

D40061

29d. Date signed (Month, Day, Year)

10/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3601 LOCH RAVEN BLVD BALTIMORE, MD 21239

DR. MELANIE BROWN

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32399

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John ROBERTS						2. Date of Death Month Oct Day 7 Year 2000		3. Time of Death 18:56										
	4a. Facility Name (If not institution, give street and number) John Hopkins Bayview Med Center						4b. City, Town, or Location of Death BALTO		4c. County of Death N/A										
Funeral Director	5. Social Security Number 218-72-8216		6. Sex M <input type="checkbox"/> F <input type="checkbox"/>		7. Age (In yrs. last birthday) 43 Yrs.		8. Date of Birth (Month, Day, Year) Dec 5, 1956		9. Birthplace (State or Foreign Country) MD										
	Usual Residence of Decedent																		
10a. State MD		10b. County BALTO		10c. City, Town or Location EDGEMERE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number 2840 LODGE FARM RD				10f. Zip Code 21222		10g. Citizen of What Country? USA													
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) NONE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BRICKLAYER			16b. Kind of Business/Industry CONSTRUCTION												
17. Father's Name (First, Middle, Last) WILBUR ROBERTS SR.						18. Mother's Name (First, Middle, Maiden Surname) GLORIA ANN WALLACE													
19a. Informant's Name/Relationship (Type, Print) GLORIA ANN ROBERTS						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2840 LODGE FARM RD. EDGEMERE MD 21222													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hills Cemetery			20c. Location - City or Town, State BALTO MD		20d. Date 10/10/00											
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility DELLANIXE LSON FUNERAL HOME 322 S. HIGH ST. BALTO MD 21202													
23a. Part I: Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Sephic Shocs Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death 4 days</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Neutropenia Due to (or as a consequence of):</td> <td>7 days</td> </tr> <tr> <td>c. Lung Sarcoma Due to (or as a consequence of):</td> <td>4 months</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. Sephic Shocs Due to (or as a consequence of):	Approximate Interval Between Onset and Death 4 days	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Neutropenia Due to (or as a consequence of):	7 days	c. Lung Sarcoma Due to (or as a consequence of):	4 months	d.	
Immediate Cause (Final disease or condition resulting in death)	a. Sephic Shocs Due to (or as a consequence of):	Approximate Interval Between Onset and Death 4 days																	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Neutropenia Due to (or as a consequence of):	7 days																	
	c. Lung Sarcoma Due to (or as a consequence of):	4 months																	
	d.																		
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								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred										
			28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier J. Green MD Intern						29c. License number Res-2001		29d. Date signed (Month, Day, Year) October, 7th 2000											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Brades MD, 4940 Eastern Avenue Baltimore, MD 21224																			
31. Date filed (Month, Day, Year) OCT 13 2000			32. Registered Signature <i>[Signature]</i>																

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32400

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Etta Smith

2. Date of Death

Oct 10 2000

3. Time of Death

9:25 Am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

220-18-6376

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

7-16-1919

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3915 Calloway Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th Grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

John Cameron

18. Mother's Name (First, Middle, Maiden Surname)

Grizzetta

19a. Informant's Name/Relationship (Type, Print)

James R. Smith, Sr - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5709 Rockspring Road Balto, Md 21209

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial Park 10-14-00

Date

20c. Location - City or Town, State

Arbutus, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

metastatic Breast Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sepsis; pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

N/A
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0015698

29d. Date signed (Month, Day, Year)

Oct 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCOS GALICIA M.D.

Bon Secours Hospital, Baltimore, Md 21223

State
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32401

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Alfred Santanoceta, Sr.

2. Date of Death

Month Day Year
October 9, 2000

3. Time of Death

11:58 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

216-20-1696

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 13, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3219 McShane Way

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8 Years

College (1-4 or 5+)

16. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Crown Cork & Seal

17. Father's Name (First, Middle, Last)

Michael Santanoceta

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Vaccarino

19a. Informant's Name/Relationship (Type, Print) (Wife)

Mrs. Marie B. Santanoceta

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3219 McShane Way Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

10/13/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. DEMENTIA

Due to (or as a consequence of):

b. MORBID OBESITY

Due to (or as a consequence of):

c. SEPSIS

Due to (or as a consequence of):

d. DEAD

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Santander H. Turner MD

29c. License number

D27188

29d. Date signed (Month, Day, Year)

10/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Santander H. Turner 2 Market - Baltimore MD 21222

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Santander H. Turner

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32402

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT SAUNDERS JR.			2. Date of Death Month OCTOBER Day 9th Year 2000		3. Time of Death 8:00 AM	
	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOSPITAL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death NA	
Funeral Director	5. Social Security Number 212-30-3530		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 01-26-34
	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Usual Residence of Decedent							
10e. Street and Number 1805 Burnwood Road				10f. Zip Code 21239		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction work	
17. Father's Name (First, Middle, Last) Robert Saunders				18. Mother's Name (First, Middle, Maiden Surname) Clara Bennett			
19a. Informant's Name/Relationship (Type, Print) Kenneth L. Saunders, Sr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 4223 Stanwood Avenue Baltimore, Maryland			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 10-14-2000 Dundalk, MD		20d. Date	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. LUNG CANCER Due to (or as a consequence of): c. BRONCHOPLEURAL FISTULA Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death 10 YEARS One week							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number P13451		29d. Date signed (Month, Day, Year) OCTOBER 9th 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BERTHA AYI GOOD SAMARITAN HOSPITAL - 5601 ROCK RAVEN BLVD. BALTIMORE, MD 21239							
31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

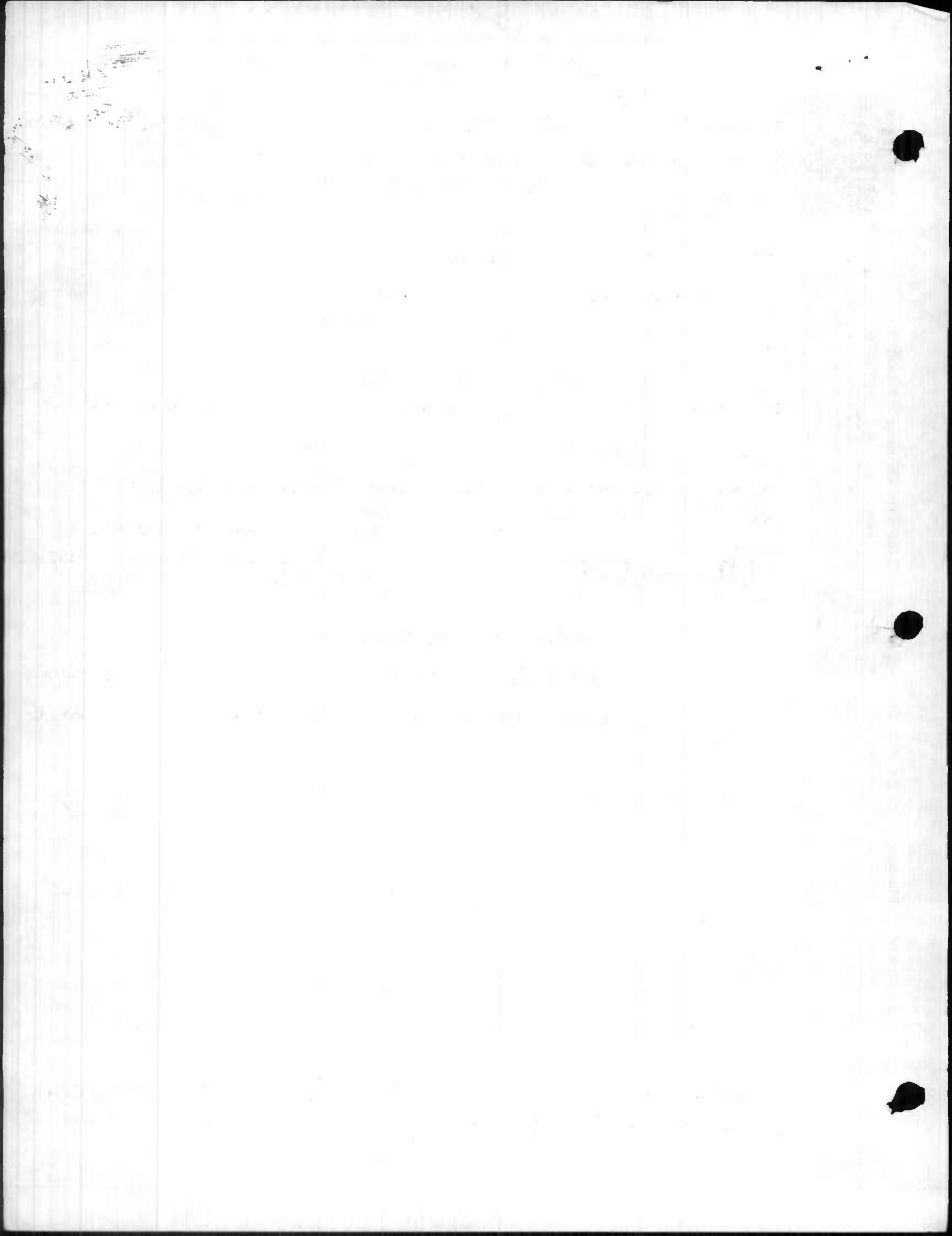
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

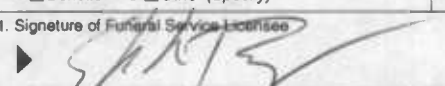
State of Maryland / Department of Health and Mental Hygiene

00 32403

Amended Item#30 per DVRG788 10/13/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KALACHAR SURYANARAYANA				2. Date of Death Month 10 Day 10 Year 2000		3. Time of Death 355 PM	
	4a. Facility Name (If not institution, give street and number) University of Maryland Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 223-53-6748		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08-11-1949	9. Birthplace (State or Foreign Country) India
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 1800 Eagle Rock Lane				10f. Zip Code 21702		10g. Citizen of What Country? United States		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Research Scientist			16b. Kind of Business/Industry Science Research	
17. Father's Name (First, Middle, Last) K. T. Kalachar				18. Mother's Name (First, Middle, Maiden Surname) Basavarajamma Kalachar				
19a. Informant's Name/Relationship (Type, Print) Mani Alapat / Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 Eagle Rock Lane Frederick, MD 21702				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Crematory		Date 10/11/00		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Skkot Cody, Licensed Mortician 44 Tremaine Ct. Baltimore, MD 21244				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Pulmonary Aspergillosis Due to (or as a consequence of): b. Wegener's Granulomatosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
						24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number P 14653		29d. Date signed (Month, Day, Year) 10-10-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BeBron K MARTIN UNIV. OF MD M&D SYSTEMS								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32404

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SONDRA SANDERS		2. Date of Death Month 10 Day 9 Year 2000		3. Time of Death 12:45PM
	4a. Facility Name (If not institution, give street and number) BON SECOUR HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 218-60-6385	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) Nov. 26, 1952
	9. Birthplace (State or Foreign Country) MARYLAND		Usual Residence of Decedent		
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County BALTIMORE	10c. City, Town or Location RANDALLSTOWN		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 3829 ELMCROFT ROAD		10f. Zip Code 21133		10g. Citizen of What Country? USA.
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) 12th GRADE		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER		16b. Kind of Business/Industry LAUNDRY MAT		
	17. Father's Name (First, Middle, Last) RICHARD BROWN		18. Mother's Name (First, Middle, Maiden Surname) DOROTHY NEWMAN		
	19a. Informant's Name/Relationship (Type, Print) RICHARD BROWN (FATHER)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3829 ELMCROFT RD. RANDALLSTOWN, MD 21133		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. Location - City or Town, State 10-1600 LANSDOWNE, MARYLAND
	21. Signature of Funeral Service Licensee <i>John Williams</i>		22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex;"> <div style="flex: 1;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="flex: 2;"> <p>a. Hepatic Encephalopathy Due to (or as a consequence of):</p> <p>b. Gastrointestinal Bleed Due to (or as a consequence of):</p> <p>c. Liver Cirrhosis Due to (or as a consequence of):</p> <p>d. Hepatitis Due to (or as a consequence of):</p> </div> </div>				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 10/9/00					
28b. Time of Injury M					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier A Reddy M.D.					
29c. License number D46305					
29d. Date signed (Month, Day, Year) 10/9/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANURADHA REDDY 1940 W Baltimore Street Baltimore MD 21223					
31. Date filed (Month, Day, Year) OCT 13 2000					
32. Registrar's Signature <i>B. Sparks</i>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32405

Amend Item 1 per phy,788,1013/00dhh

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Thieler</u> Angela Thieler				2. Date of Death Month Day Year <u>10</u> <u>06</u> <u>00</u>			3. Time of Death <u>1220</u>											
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Med. Ctr.</u>				4b. City, Town, or Location of Death <u>Baltimore MD</u>			4c. County of Death											
Funeral Director	5. Social Security Number <u>575-37-3386</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>27</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>JAN. 4, 1973</u>		9. Birthplace (State or Foreign Country) <u>CALIFORNIA</u>										
	Usual Residence of Decedent																		
10a. State <u>MARYLAND</u>		10b. County		10c. City, Town or Location <u>BALTIMORE</u>				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
10a. Street and Number <u>3616 COOLIDGE AVE.</u>				10f. Zip Code <u>21229</u>			10g. Citizen of What Country? <u>USA</u>												
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>ADMINISTRATIVE ASSISTANT</u>			16b. Kind of Business/Industry <u>ENVELOPE COMPANY</u>												
17. Father's Name (First, Middle, Last) <u>RICHARD L BURDESS</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>BRENDALEE T CLEMONDS</u>														
19a. Informant's Name/Relationship (Type, Print) <u>ROBERT LEE THIELER</u>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3616 COOLIDGE AVE., BALTIMORE, MD 21229</u>														
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>LOUDON PARK CEMETERY</u>		Date <u>10/11/00</u>		20c. Location - City or Town, State <u>BALTIMORE, MD</u>												
21. Signature of Funeral Service Licensee					22. Name and Address of Facility <u>LOUDON PARK FUNERAL HOME</u> <u>3620 WILKENS AVE., BALTIMORE, MD 21229</u>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Probable CNS BLEED</u></td> <td rowspan="4">Approximate Interval Between Onset and Death <u>15 min</u></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <u>Acute Myelogenous Leukemia</u></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <u>Probable CNS BLEED</u>	Approximate Interval Between Onset and Death <u>15 min</u>	Due to (or as a consequence of):	b. <u>Acute Myelogenous Leukemia</u>	Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)	a. <u>Probable CNS BLEED</u>	Approximate Interval Between Onset and Death <u>15 min</u>																	
	Due to (or as a consequence of):																		
	b. <u>Acute Myelogenous Leukemia</u>																		
	Due to (or as a consequence of):																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as a consequence of):																	
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier <u>Judith E. Karp, MD</u>					29c. License number <u>D17912</u>		29d. Date signed (Month, Day, Year) <u>10/6/00</u>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Judith E. Karp MD Univ. of MD GREENEBAUM CANCER Ctr. 22 S. GREENE ST.</u>																			
31. Date filed (Month, Day, Year) <u>OCT 13 2000</u>					32. Registrar's Signature <u>B. Sparks</u>														

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32406

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MELVIN RICHARD THOMPSON				2. Date of Death Month Day Year Oct 8, 2000		3. Time of Death 1823
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital			4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 212 28 0471	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 22, 1931	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 1706 HOMESTEAD STREET			10f. Zip Code 21218		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Korean Conflict		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST		16b. Kind of Business/Industry Book Binding
	17. Father's Name (First, Middle, Last) FLOYD THOMPSON			18. Mother's Name (First, Middle, Maiden Surname) Lillian Williams			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Karen Bernards / Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2920 Ruskin Court ABINGDON, Maryland 21009			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Veterans Cemetery		20c. Location - City or Town, State 1016 Bow Swings Mills, Maryland		
	21. Signature of Funeral Service Licensee [Signature]			22. Name and Address of Facility CARTER-HARRIS Funeral Home 5340 REISTERSTOWN ROAD BALTIMORE MD 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Left leg ulcer Due to (or as a consequence of): d. Anaemia Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D 31464		29d. Date signed (Month, Day, Year) 10/12/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOABIS A. HASSANI 821 N. Eutam St Suite 308 Balt MD 21201							
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature [Signature]					

ORIGINAL

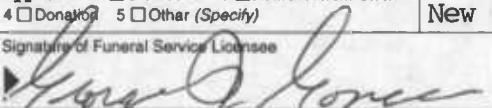

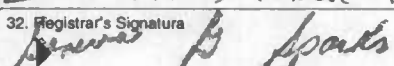
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32407

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary C. Tasker				2. Date of Death Month October Day 9 Year 2000		3. Time of Death 4:25 P.M.	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Multi-Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215 01 2981		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) March 21, 1913	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 102 S. Poppleton Street		10f. Zip Code 21201		10g. Citizen of What Country? U.S.	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria worker		16b. Kind of Business/Industry Maryland Drydock			
	17. Father's Name (First, Middle, Last) Julian Stelmach				18. Mother's Name (First, Middle, Maiden Sumama) Josephine Klisczwska			
	19a. Informant's Name/Relationship (Type, Print) Leo Holden / Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 S. Poppleton Street Baltimore, Maryland 21201			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cramation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State 10/12/00 Baltimore, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Constrictive Heart Failure Due to (or as a consequence of): b. Arteriosclerotic Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation stroke						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D17118		29d. Date signed (Month, Day, Year) Oct 10, 2000				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Paul Schwartz MD 115 E Melrose Ave 21212								
31. Date filed (Month, Day, Year) OCT 13 2000		32. Registrar's Signature 						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32408

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Oswald Vonbehren				2. Date of Death Month October Day 11 Year 2000		3. Time of Death 16:45	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 213-05-2627		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) April 27, 1911	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Parkville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 6607 Glenoak Ave.		10f. Zip Code 21234	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) plumber				16b. Kind of Business/Industry Amendt		17. Father's Name (First, Middle, Last) Frederick William von Behren	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Saalkrach				19a. Informant's Name/Relationship (Type, Print) Margaret E. Blades		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15010 Lavale Rd. Monkton, Md 21111	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. Location - City or Town, State Parkville, Md	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Kevin B. Wolfe				22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) October 11, 2000			
	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier David				29c. License number P12558			
	29d. Date signed (Month, Day, Year) October 11, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maral Donabedian 5601 Loch Raven Blvd Baltimore MD 21239			
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature David			
	33. Registrar's Signature David				34. Registrar's Signature David			

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32409

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Steven Alfred Vaccacio				2. Date of Death Month October Day 7 Year 2000		3. Time of Death 7:25pm	
	4a. Facility Name (If not institution, give street and number) St. Joseph's Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 151-52-5703		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) June 30, 1956	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Monkton	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 9 Manor Brook Road		10f. Zip Code 21111	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Insurance Salesman				16b. Kind of Business/Industry Insurance			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Alfred Joseph Vaccacio				18. Mother's Name (First, Middle, Maiden Surname) Ruth Anita Krueger			
	19a. Informant's Name/Relationship (Type, Print) Donna Vaccacio/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Manor Brook Road, Monkton, Maryland 21111			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. 10/11/00 Timonium, Maryland			
	21. Signature of Funeral Service Licensee Bryan W. Clary				22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of):				Approximate Interval Between Onset and Death acute			
	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)			
	28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier June Breiner MD			
	29c. License number D40208				29d. Date signed (Month, Day, Year) October 9, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) June Breiner, MD 1205 York Road, suite 32C, Lutherville, MD 21093				31. Date filed (Month, Day, Year) OCT 13 2000			
	32. Registrar's Signature [Signature]							

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 00 32410

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEANETTA ODESSA WARD				2. Date of Death Month Day Year OCTOBER 6, 2000		3. Time of Death 13:42 PM	
	4a. Facility Name (If not institution, give street and number) 810 QUEENSTOWN ROAD				4b. City, Town, or Location of Death SEVERN		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 216-22-3641		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) MAY 8 1913	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County A.A.CO		10c. City, Town or Location GLEN BURNIE	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1412 JOHN STREET		10f. Zip Code 21061	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOMESTIC				16b. Kind of Business/Industry FORT MEADE		17. Father's Name (First, Middle, Last) UREL DOMNEY	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) BEATRICE HALL				19a. Informant's Name/Relationship (Type, Print) Sandora Bouyer/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Queenstown Rd., Severn, Maryland 21144	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND NATIONAL		20c. Location - City or Town, State 10-11-00 LAUREL, MARYLAND	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number O.C.M.E.			
	29d. Date signed (Month, Day, Year) OCTOBER 10, 2000				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201			
State Registrar	31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature 			

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32411

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Maud H. Wadford				2. Date of Death Month Day Year October 5, 2000		3. Time of Death 1:25 AM	
	4a. Facility Name (If not institution, give street and number) 1473 Gesna Drive				4b. City, Town, or Location of Death Hanover		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220-70-0412		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 23, 1932	
	9. Birthplace (State or Foreign Country) British Honduras		10a. State Md.		10b. County Howard		10c. City, Town or Location Laurel	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 448 Old Line Ave.		10f. Zip Code 20724		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Health Aid		16b. Kind of Business/Industry Health Care		17. Father's Name (First, Middle, Last) Herbert Lind	
	18. Mother's Name (First, Middle, Maiden Surname) Maud Sebastian		19a. Informant's Name/Relationship (Type, Print) Kathy Chrystal - daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1473 Gesna Dr., Hanover, Md. 21076		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		20c. Location - City or Town, State Arlington, Va.		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc 7250 Washington Blvd., Elkridge, MD 21075	
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Lung Cancer b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Daughter's Room		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28b. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>	
To Be Completed by Physician/Medical Examiner	29c. License number A24356		29d. Date signed (Month, Day, Year) October 9, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm C Waterfield MD St Agnes Cancer Center 900 Calver Ave Balt Md 21229		31. Date filed (Month, Day, Year) OCT 13 2000	
	32. Registrar's Signature <i>[Signature]</i>		33. State Registrar 20		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.	

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

60 32412

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Earl Wallace Sr.						2. Date of Death Month Day Year October 10, 2000			3. Time of Death 10:35 PM		
	4a. Facility Name (If not institution, give street and number) Harbor Hospital						4b. City, Town, or Location of Death Baltimore			4c. County of Death N/A		
Funeral Director	5. Social Security Number 218-14-0900		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Dec. 23, 1924	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Linthicum				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 604 Cleveland Road						10f. Zip Code 21090			10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Stone Mason				16b. Kind of Business/Industry Self-employed			
	17. Father's Name (First, Middle, Last) John Wallace						18. Mother's Name (First, Middle, Maiden Surname) Emma Griffin					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Wallace - daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Cleveland Rd., Linthicum, Md. 21090					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park				Date 10/13/00		20c. Location - City or Town, State Elkridge, Md.	
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arrhythmic Due to (or as a consequence of): b. Arterio Sclerotic Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 Day Years											
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus											
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier 						29c. License number 00023811			29d. Date signed (Month, Day, Year) 10/12/00		
10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Forman MD 1406 B.S. Crain Glen Burnie MD 21061											
	31. Date filed (Month, Day, Year) OCT 13 2000				32. Registrar's Signature 							

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State of Maryland / Department of Health and Mental Hygiene

00 32413

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Alan Weidner			2. Date of Death Month Day Year October 02, 2000			3. Time of Death 2:30 P.M.		
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center			4b. City, Town, or Location of Death Randallstown			4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 214 54 9130	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 16, 1965		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Eldersburg			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2310 Todd Lane				10f. Zip Code 21784		10g. Citizen of What Country? U.S.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1 year			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronic Technician			16b. Kind of Business/Industry S.A.F.T.			
17. Father's Name (First, Middle, Last) Joseph A. Weidner				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Phylliss Lackwitz					
19a. Informant's Name/Relationship (Type, Print) Joseph Weidner / Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2310 Todd Lane Eldersburg, Maryland 21784					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory, Inc.		Date 10/5/00		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE AMITRIPTYLINE INTOXICATION a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) 9-26-00		28b. Time of Injury 5:00p M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred unknown			28e. Location (Street and Number or Rural Route Number, City or Town, State) 32 Brookebury Dr., REISTERSTOWN, MD Apt. D1			
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 04, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) 001 13 2000			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32414

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA LOUISE

2. Date of Death

September 16, 2000

3. Time of Death

18 45

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-34-1571

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02-Apr-36

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Garrett

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 Wilhelm Lane

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

homemaker

17. Father's Name (First, Middle, Last)

Lawrence L. Layton

18. Mother's Name (First, Middle, Maiden Surname)

Clara E. McKenzie

19a. Informant's Name/Relationship (Type, Print)

Stephen C. Albright husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Wilhelm Lane Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Layton Cemetery

Date

19-Sep-00

20c. Location - City or Town, State

Anzel, Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

5 min

Due to (or as a consequence of):

b. ADVANCED PERITONEAL CANCER

14 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMATOUS ILEUS

SEVERE THROMBOCYTOPENIA

NEUTROPENIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Carolyn Alexander

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

September 17, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2239 ROGENE DRIVE Apartment T3 BALTIMORE, MD 21209

State
Registrar

31. Date filed (Month, Day, Year)

SEP 18 2000

32. Registrar's Signature

Beverly Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitTo Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

200-24-1241

as

00-401-04

Westford

Mayland

Condit

Rosburg

2 Wilhelm Lane

11-000

11-000

Westford

Westford

Westford

0

8

Clair E. McKinnis

Lawrence E. Jovon

Rosburg Maylor

2 Wilhelm Lane

Westford

Stephen C. Albright

11-240-00 (Westford)

Westford Cemetery

First Funeral Home, 77 Post Ave., Westford, Mass.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32415

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FREDERICK EUGENE AIRESMAN				2. Date of Death Month Day Year OCTOBER 2 2000		3. Time of Death 3 PM	
	4a. Facility Name (If not institution, give street and number) 1307 KENTUCKY AVENUE				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 216-38-1905	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUGUST 6 1940		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10e. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 1307 KENTUCKY AVENUE				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CITY OF CUMBERLAND			16b. Kind of Business/Industry ENGINEERING DEPT.	
17. Father's Name (First, Middle, Last) HARRY AIRESMAN				18. Mother's Name (First, Middle, Maiden Sumame) FRANCES McDONALD				
19e. Informant's Name/Relationship (Type, Print) BONNIE AIRESMAN WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1307 KENTUCKY AVENUE CUMBERLAND MARYLAND 21502				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY OCT 3 2000			20c. Location - City or Town, State CUMBERLAND MARYLAND	
21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Endstage Dementia</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>2 yrs</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Respiratory failure</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>						
29c. License number D 22181		29d. Date signed (Month, Day, Year) OCTOBER 3, 2000						
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) DR GARY L. WAGONER 925 BISHOP WALSH DRIVE CUMBERLAND MARYLAND 21502								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature or initials.

0001-10-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32416

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUSSELL NMN BRECHBILL				2. Date of Death Month Day Year September 27 2000		3. Time of Death 1921	
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County	
Funeral Director	5. Social Security Number 204-03-5086		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 14, 1909	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Washington County		10c. City, Town or Location Smithsburg	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 20837 Jefferson Boulevard		10f. Zip Code 21783		
10g. Citizen of What Country? U.S.A.		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Aircraft Manufacturing		
17. Father's Name (First, Middle, Last) Harvey Brechbill				18. Mother's Name (First, Middle, Maiden Surname) Ida Elizabeth Cramer				
19a. Informant's Name/Relationship (Type, Print) Glenna E. Brechbill/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20837 Jefferson Boulevard, Smithsburg, Maryland				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Air Hill Cemetery		Date Sept. 30		20c. Location - City or Town, State Air Hill, Pennsylvania		
21. Signature of Funeral Service Licensee Kelley A. Zimmerman				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Anterior wall myocardial infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus chronic Renal Insufficiency Probable Carcinoma Prostate								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D18019		29d. Date signed (Month, Day, Year) Sept 28, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Datta 334 mill St. Hagerstown, MD 21740								
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature [Signature]						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32417

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Lee Barnes, Sr.

2. Date of Death

Month Day Year
Sept. 28 2000

3. Time of Death

11:03 p.m.

4a. Facility Name (If not institution, give street and number)

135 Plantation Drive

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

578-36-4765

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
10/13/1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

135 Plantation Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 194713. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Alva E. Barnes

18. Mother's Name (First, Middle, Maiden Summa)

Ada Burgess

19a. Informant's Name/Relationship (Type, Print)

Lois Ann Barnes / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

135 Plantation Dr. Hagerstown, MD 21740

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery

Date

10/2/00

20c. Location - City or Town, State

Hagerstown, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rest Haven Funeral Chapel

1601 Pennsylvania Ave. Hagerstown, MD 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)End Stage liver disease / failure weeks
Due to (or as a consequence of):
Metastatic Neoplastic disease MonthsSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) LastDue to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0031880

29d. Date signed (Month, Day, Year)

9/29/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Gallagher Robinwood Med. Ctr, Suite 226, Hagerstown

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
2025To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32418

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALDUS SHARON BONEBRAKE				2. Date of Death Month Day Year September 28 2000		3. Time of Death 23:10				
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON				
Funeral Director	5. Social Security Number 173031268		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) OCT 14, 1916				
	9. Birthplace (State or Foreign Country) FRANKLIN, PA.		10a. State PA		10b. County FRANKLIN		10c. City, Town or Location WAYNESBORO				
Usual Residence of Decedent											
10d. Inside City Limits 1 Yes 2 No			10e. Street and Number 109 N. FRANKLIN ST			10f. Zip Code 17268		10g. Citizen of What Country? USA			
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COST ACCOUNTANT			16b. Kind of Business/Industry MACHINING TOOL MFG.					
17. Father's Name (First, Middle, Last) CYRUS N BONEBRAKE					18. Mother's Name (First, Middle, Maiden Surname) MARY REBECCA ZODY						
19a. Informant's Name/Relationship (Type, Print) LINDA M THORNTON/AUG.					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 CLAYTON AVE WAYNESBORO PA 17268						
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN HILL CEMETERY			20c. Date OCT 2		20d. Location - City or Town, State WAYNESBORO, PA			
21. Signature of Funeral Service Licensee James A Bowersox					22. Name and Address of Facility GROVE-BOWERSOX FUNERAL HOME 505 BROAD ST WAYNESBORO PA 17268						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): CONGESTIVE HEART FAILURE Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of): CEREBROVASCULAR ACCIDENT									Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITIS DEKUBITIS ULCERS									23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
24a. Was an autopsy performed? 1 Yes 2 No			24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
25. Was case referred to medical examiner? 1 Yes 2 No			26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier M. B. Sparks			29c. License number DS2323			29d. Date signed (Month, Day, Year) 09/29/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KHALID WASEEM 19414 C LINTERSBURG PIKE HAGERSTOWN MD 21742											
31. Date filed (Month, Day, Year) OCT 02 2000			32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Aldus Sharon BoneBrake

Amend # 236, 9/23/00
NHL, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32419

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROY KILGORE BROWN				2. Date of Death Month Day Year SEPT 24 2000		3. Time of Death 10:16 A.M.	
	4a. Facility Name (If not institution, give street and number) SACRED HEART HOSPITAL				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 215 26 6245		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) NOV 23 1930	
	Usual Residence of Decedent		10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location FROSTBURG	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 10613 WASHINGTON HOLLOW ROAD, SW			
	10f. Zip Code 21532				10g. Citizen of What Country? U.S.			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates KOREAN CONFLICT		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SHIPPING DEPARTMENT		16b. Kind of Business/Industry TIRE BUILDING			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JAMES E. BROWN				18. Mother's Name (First, Middle, Maiden Summa) FLORENCE KIDDY			
	19a. Informant's Name/Relationship (Type, Print) BRENDA ATHEY / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532 10613 WASHINGTON HOLLOW ROAD, SW, FROSTBURG, MD			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FROSTBURG MEMORIAL PARK		20c. Location - City or Town, State FROSTBURG, MD		20d. Date 9/27/00	
	21. Signature of Funeral Service Licensee <i>Maureen M. Sowers</i>		22. Name and Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>cardiac arrest</i> Due to (or as a consequence of): b. <i>athero-sclerotic cardiac disease</i> Due to (or as a consequence of): c. <i>diabetes mellitus</i> Due to (or as a consequence of): d. <i>peripheral vascular disease and gangrene</i>						Approximate Interval Between Onset and Death <i>5 yrs +</i> <i>5 yrs +</i> <i>6 mos</i>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <i>William E. Palin</i>	
	29c. License number D34653		29d. Date signed (Month, Day, Year) September 26 2000					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM E. PALIN, M.D., JOHNSON HEIGHTS MEDICAL BLDG, CUMBERLAND, MD 21502						31. Date filed (Month, Day, Year) SEP 28 2000	
	32. Registrar's Signature <i>James B. Sparks</i>							

Handwritten signature or initials.

SEP 18 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND# 18 10/4/00 cmh AACO HEALTH DEPT State of Maryland / Department of Health and Mental Hygiene 00 32420
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Verna C. Blizard				2. Date of Death Month Day Year Sept. 22, 2000				3. Time of Death 4:15 pm	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Hospital				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 139-03-5780		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Nov 4, 1917		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Severna Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 715 Benfield Road				10f. Zip Code 21146				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Executive Secretary				16b. Kind of Business/Industry Campbell Soup Co.		
17. Father's Name (First, Middle, Last) Frank Croker				18. Mother's Name (First, Middle, Maiden Surname) Emily Thease Thees						
19a. Informant's Name/Relationship (Type, Print) Carol Bishop/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 340 Redwood Grove Court, Millersville, MD 21108						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Park			Date Sept 26 2000		20c. Location - City or Town, State Cinnaminson, NJ		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of): b. <u>ASPIRATION PNEUMONIA</u> Due to (or as a consequence of): c. <u>PULMONARY FIBROSIS</u> Due to (or as a consequence of): d. _____ Approximate Interval Between Onset and Death T WEEK										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DEMENTIA</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D39037				29d. Date signed (Month, Day, Year) 9/22/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH, AAMC, ANNAPOLIS MD 21401										
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

235 S 2 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32421

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SAMUEL BUTLER				2. Date of Death Month Day Year SEPT. 21 2000		3. Time of Death 3:15 am	
	4a. Facility Name (If not institution, give street and number) 808 RICHARD TONGUE DRIVE				4b. City, Town, or Location of Death MILLERSVILLE		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 214-50-9943	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) FEB. 21 1948		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location MILLERSVILLE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. Street and Number 808 RICHARD TONGUE DRIVE				10f. Zip Code 21108		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7th 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) JANITOR			16b. Kind of Business/Industry BUTLER JANITORAL	
17. Father's Name (First, Middle, Last) JAMES E. BUTLER				18. Mother's Name (First, Middle, Maiden Surname) FRANCES NAYLOR				
19a. Informant's Name/Relationship (Type, Print) JANET W. BUTLER (WIFE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21108 808 RICHARD TONGUE DR. MILLERSVILLE, MD.				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY		20c. Location - City or Town, State 9/25/00 GLEN BURNIE, MD.		
21. Signature of Funeral Service Licensee Harry D. Reese M00482				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. Adenocarcinoma unknown Due to (or as a consequence of): b. Bone metastases Due to (or as a consequence of): c. Hypercalcemia Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier D. M. D.				29c. License number D39505		29d. Date signed (Month, Day, Year) September 22, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Markan 1600 Chain Hwy, Glen Burnie, MD 21061								
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature B. A. Smith				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, possibly a signature or date, located in the center of the page.

Handwritten signature or initials at the bottom center of the page.

269 3 8 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32422

Martha Butler

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Martha Pearl Butler				2. Date of Death Month Day Year October 6 2000				3. Time of Death 1350	
4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton				4c. County of Death Talbot	
5. Social Security Number 213-14-1985		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 22, 1916		9. Birthplace (State or Foreign Country) Indiana	
Usual Residence of Decedent									
10a. State Maryland		10b. County Caroline		10c. City, Town or Location Denton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 24150 Willow Pond Road				10f. Zip Code 21629		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Legal Secretary			16b. Kind of Business/Industry University of Maryland Extension Service		
17. Father's Name (First, Middle, Last) Elmer Joseph Clem				18. Mother's Name (First, Middle, Maiden Surname) Bessie Ann Myers					
19a. Informant's Name/Relationship (Type, Print) Loisann B. Pearsall Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24078 Willow Pond Road, Denton, Maryland 21629					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Denton Cemetery		Date 10/10/00		20c. Location - City or Town, State Denton, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Papillary serous carcinoma of uterus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death 7 months			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 123887		29d. Date signed (Month, Day, Year) 10/7/00			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David H. Smith, M.D., 29466 Pintail Drive, Suite 5 & 6, Easton, Maryland 21629									
31. Date filed (Month, Day, Year) OCT 11 2000		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32423

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kennard Wheatley Blades				2. Date of Death Month Day Year October 4 2000		3. Time of Death 1:26 PM		
	4a. Facility Name (If not institution, give street and number) Corsica Hills Nursing Home				4b. City, Town, or Location of Death Centreville		4c. County of Death Queen Anne		
Funeral Director	5. Social Security Number 221-12-9106	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/22/1922		9. Birthplace (State or Foreign Country) Delaware	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Md	10b. County Caroline	10c. City, Town or Location Denton			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 10603 Knife Box Road				10f. Zip Code 21629		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer			16b. Kind of Business/Industry sign making			
	17. Father's Name (First, Middle, Last) Harlan Russell Blades				18. Mother's Name (First, Middle, Maiden Surname) Lola Mae Fountain				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Alberta A. Blades/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10603 Knife Box Road, Denton, Md. 21629				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Denton Cemetery		20c. Date Oct. 7 2000		20d. Location - City or Town, State Denton, Maryland		
	21. Signature of Funeral Service Licensee <i>R. Randolph P. Moore</i>				22. Name and Address of Facility Moore Funeral Home, P.A. 12 S. 2nd Street, Denton, Md. 21629				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <i>Urinary tract infection</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):							Approximate Interval Between Onset and Death <i>1 wk</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer Dementia</i>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>A. J. Spruill</i>		29c. License number D32036		29d. Date signed (Month, Day, Year) 10/5/2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Guy J. Spruill 2100 D. Douth Drive Charles MD 21619									
31. Date filed (Month, Day, Year) OCT 10 2000		32. Registrar's Signature <i>B. Sparks</i>							

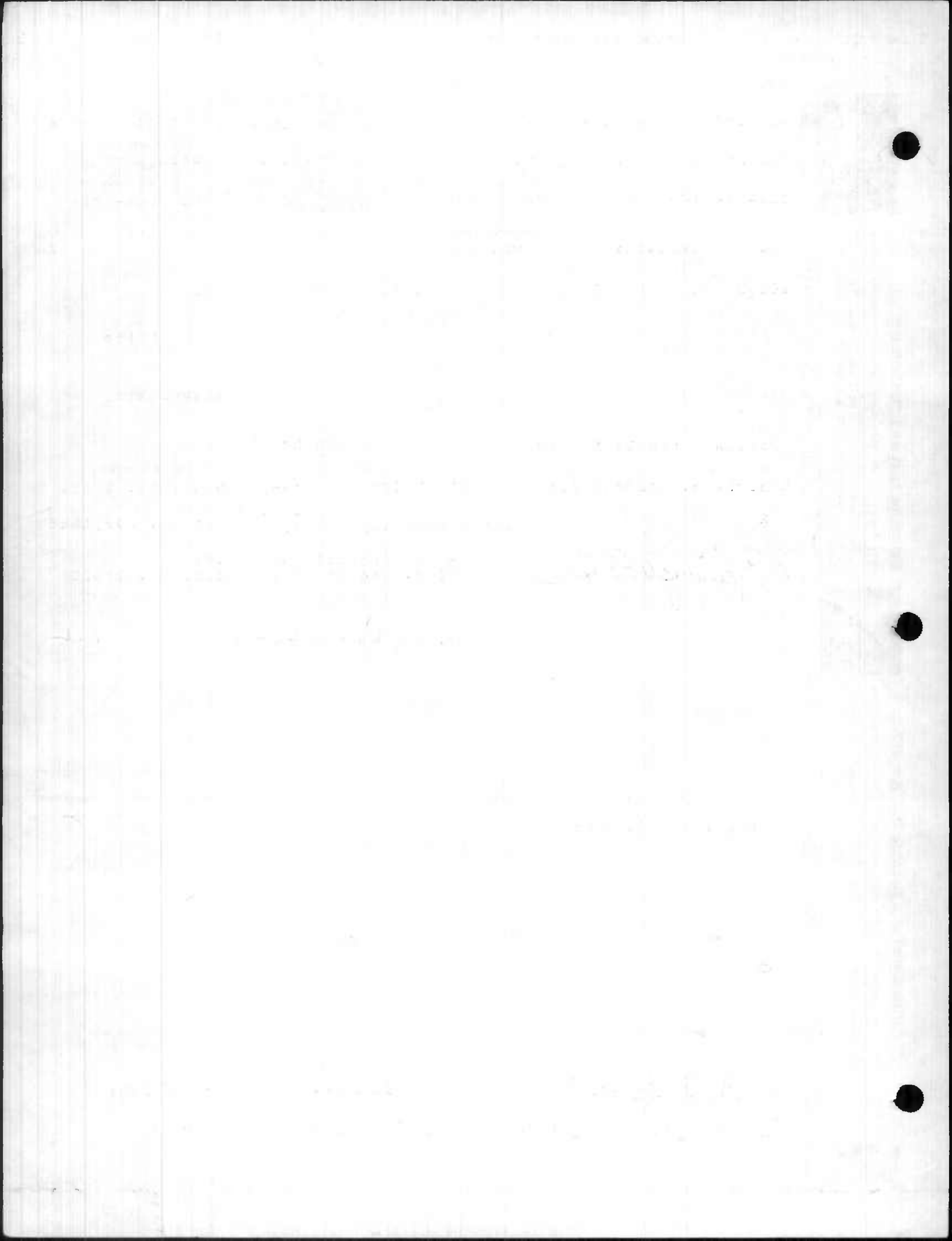
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended
Line 3./WCHD/SC
October 3, 2000

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32424

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Marie GOUKER

2. Date of Death

Month Day Year
October 2, 2000

3. Time of Death

A.M.
12:15 PMFuneral
Director

4a. Facility Name (If not institution, give street and number)

9620 June Avenue

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

086-40-0785

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 25, 1948

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9620 June Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
016a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

draft technician

16b. Kind of Business/Industry

beverage distributor

17. Father's Name (First, Middle, Last)

James L. Comer

18. Mother's Name (First, Middle, Maiden Surname)

Grace Marie Santoro

19a. Informant's Name/Relationship (Type, Print)

Robert L. Gouker - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9620 June Ave., Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

10-4-00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Boulevard, Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46473

29d. Date signed (Month, Day, Year)

10/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda Hammon, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740

State
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

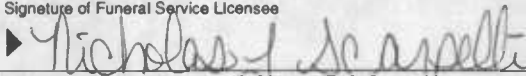
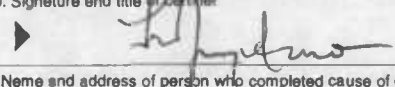

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32425

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Susie Lucinda Cox			2. Date of Death Month: 9 Day: 29 Year: 2000		3. Time of Death 11:14 AM							
	4a. Facility Name (If not institution, give street and number) Memorial Hospital			4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany							
Funeral Director	5. Social Security Number 218-52-2807		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) Jun 9, 1905						
	10e. State WV		10b. County Mineral		10c. City, Town or Location Wiley Ford		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Usual Residence of Decedent													
10e. Street and Number Route 1 Box 55				10f. Zip Code 26767		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker		16b. Kind of Business/Industry own home							
17. Father's Name (First, Middle, Last) George Seymour Baldwin				18. Mother's Name (First, Middle, Maiden Surname) Mary A (Abe)									
19a. Informant's Name/Relationship (Type, Print) James Cox husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 55; Wiley Ford WV 26767									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Abe Cemetery		Date 10/02 2000		20c. Location - City or Town, State Short Gap, WV							
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502									
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. CORONARY ARTERY DISEASE Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CORONARY ARTERY DISEASE Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):	d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) { Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CORONARY ARTERY DISEASE Due to (or as a consequence of):	Approximate Interval Between Onset and Death											
	b. _____ Due to (or as a consequence of):												
	c. _____ Due to (or as a consequence of):												
	d. _____ Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 				29c. License number D0033280		29d. Date signed (Month, Day, Year) Sept 29, 2000							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUNIL K., GUPTA, JOHNSON HEIGHTS MEDICAL BLDG., 625 KENT AVE., CUMBERLAND, MD 21502													
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 											

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

32

Handwritten signature or initials.

0005 1.0 700

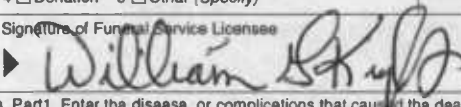
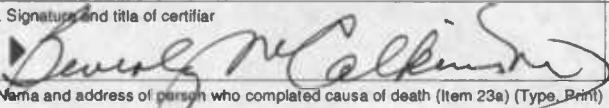
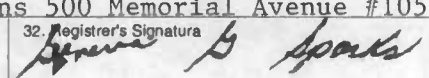
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32426

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Hetic Cooper					2. Date of Death Month Day Year October 1, 2000		3. Time of Death 20:15
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center					4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany
Funeral Director	5. Social Security Number 214-07-4585	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 10, 1917		9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Allegany	10c. City, Town or Location Cumberland			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 322 Davidson Street			10f. Zip Code 21502		10g. Citizen of What Country? USA		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trucker			16b. Kind of Business/Industry Textile Co.		
	17. Father's Name (First, Middle, Last) Wilbur C. Cooper				18. Mother's Name (First, Middle, Maiden Surname) Hattie (Royce)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Hilda C. Cooper				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 322 Davidson Street, Cumberland, MD 21502			
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park		Data 10/5/00		20c. Location - City or Town, State Cumberland, MD 21502	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrhythmia Due to (or as a consequence of): b. Coronary Heart Disease Due to (or as a consequence of): c. Atherosclerosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 20 minutes years years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Pneumonia, Lung Cancer							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D0054411		29d. Date signed (Month, Day, Year) October 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Beverly M. Calkins 500 Memorial Avenue #105 Cumberland, MD 21502								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

1880

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32427

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PRISCILLA COLLINS				2. Date of Death Month Day Year SEPT. 21 2000		3. Time of Death 12:45 am		
	4a. Facility Name (If not institution, give street and number) 4070 OLD MUDDY CREEK ROAD				4b. City, Town, or Location of Death EDGEWATER		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 214-14-0893	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 9 1918		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location EDGEWATER		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4070 OLD MUDDY CREEK ROAD				10f. Zip Code 21037		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEKEEPING		16b. Kind of Business/Industry CROWNSVILLE STATE HOSPITAL				
	17. Father's Name (First, Middle, Last) BENJAMIN COLLINS SR.				18. Mother's Name (First, Middle, Maiden Surname) HENRIETTA HALL				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ALICE SHARPS (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4070 OLD MUDDY CREEK RD. EDGEWATER, MD. 21037				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHEWS CHURCH CEMETERY		20c. Location - City or Town, State 9/26/00 OWENSVILLE, MD.				
	21. Signature of Funeral Service Licensee Harry B. Reese M00482				22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Alzheimers Dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 10 days 2 years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Wayne P. Bierbaum MD		29c. License number D38563		29d. Date signed (Month, Day, Year) September 25, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne P. Bierbaum MD 134 Owensville Road, West River, MD									
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature [Signature]							

Handwritten signature or initials.

0005 8 3 932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32428

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Lee Collins				2. Date of Death Month Day Year September 25 2000				3. Time of Death 4:15 PM	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 208-32-4472		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) March 25 1941		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent				10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Arnold	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 1280 Double Day Drive				10f. Zip Code 21012	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Home				17. Father's Name (First, Middle, Last) William Kephart	
	18. Mother's Name (First, Middle, Maiden Surname) Nellie Somers				19a. Informant's Name/Relationship (Type, Print) Joseph Collins/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1280 Double Day Drive, Arnold, MD 21012	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens				20c. Location - City or Town, State Davidsonville, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. <u>Bleomycin Lung toxicity</u> Due to (or as a consequence of): b. <u>Hodgkin's disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 				29c. License number D48006				29d. Date signed (Month, Day, Year) September 25, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOFI BOAHITEY, 301 Hosp. Dr, Glen Burnie, MD 21061				31. Data filed (Month, Day, Year) SEP 27 2000				32. Registrar's Signature 		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32429

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth H. Crandall, Jr.				2. Date of Death Month October Day 6 Year 2000		3. Time of Death 1118	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 546-46-6501		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 21, 1933	9. Birthplace (State or Foreign Country) Texas
	Usual Residence of Decedent							
10a. State GA		10b. County Fulton		10c. City, Town or Location Atlanta			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 9220 Huntcliff Trace				10f. Zip Code 30350		10g. Citizen of What Country? United States		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Engineer			16b. Kind of Business/Industry TeleCommunications	
17. Father's Name (First, Middle, Last) Kenneth H. Crandall, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Claire Wofford				
19a. Informant's Name/Relationship (Type, Print) Janet G. Crandall/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 922 Huntcliff Trace, Atlanta, GA 30350				
20a. Method of Disposition 1 Burial 2 <input checked="" type="checkbox"/> Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory		20c. Location - City or Town, State 10/6 Cambridge, MD		
21. Signature of Funeral Service Licensee Michael F. Eskew				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Carcinoma - Metastatic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 4 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 <input checked="" type="checkbox"/> Probably 4 Unknown		
						24a. Was an autopsy performed? 1 Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Mr. B. M. Shields				29c. License number D41232		29d. Date signed (Month, Day, Year) 10/6/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary DeShields, M.D., 509 Idlewild Ave., Easton, MD 21601								
31. Date filed (Month, Day, Year) OCT 10 2000		32. Registrar's Signature B. Sparks						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Kenneth Crandall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32430

Amend Item #10e., 10600. per Certificate of Death Co. AS

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID ROBERT CRANDELL		2. Date of Death Month October Day 1 Year 2000		3. Time of Death 1215
	4a. Facility Name (If not institution, give street and number) 310 Park Avenue		4b. City, Town, or Location of Death Federalsburg		4c. County of Death Caroline
Funeral Director	5. Social Security Number 213-62-2706	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jan. 21, 1953		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County Caroline		10c. City, Town or Location Federalsburg	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 310 Park Avenue 301 Park Avenue		10f. Zip Code 21632	
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 70-72	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurant Cook		16b. Kind of Business/Industry Food Service			
17. Father's Name (First, Middle, Last) Donald Charleston Crandell, Sr.			18. Mother's Name (First, Middle, Maiden Sumama) Sally Marie Elzey		
19a. Informant's Name/Relationship (Type, Print) Joyce A. Crandell/Spouse			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Park Ave., Federalsburg, MD 21632		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Veterans Cemetery		20c. Location - City or Town, State 10/4 Hurlock, Maryland	
21. Signature of Funeral Service Licensee Michael F. Ecken		22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hepatic encephalopathy Due to (or as a consequence of): b. Liver cirrhosis Due to (or as a consequence of): c. Hepatitis C Due to (or as a consequence of): d.					Approximate Interval Between Onset and Death 1.5 M 27 10 Y
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deeparoma					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier Dr. Petr Hausner		29c. License number D48160		29d. Date signed (Month, Day, Year) 10/3/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETR HAUSNER, MD, PhD, 10 N Greene St, Baltimore 21201					
31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature Deanne A. Spence			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

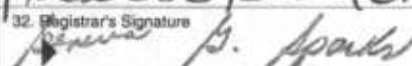
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32431

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Conyer				2. Date of Death Month Day Year Sept 30 2000		3. Time of Death 8:00 AM	
	4a. Facility Name (If not institution, give street and number) 23635 Henry Road				4b. City, Town, or Location of Death Ridgely		4c. County of Death Caroline	
Funeral Director	5. Social Security Number 214-90-6090		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 1, 1913	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Caroline		10c. City, Town or Location Ridgely			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 23635 Henry Road				10f. Zip Code 21660		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown Collega (1-4or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown		
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown				
19a. Informant's Name/Relationship (Type, Print) Steve Fleegle / mortician				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 160 Greensboro, Maryland 21639				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sandtown Memorial Park		Date Oct 6, 2000		20c. Location - City or Town, State Hillsboro, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fleegle-Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARCINOMA OF THE LUNG Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHRONIC OBSTRUCTIVE LUNG DISEASE								Approximate Interval Between Onset and Death 1 1/2 YEARS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier C.E. Jensen MD Deputy M.E.		29c. License number D14664		29d. Date signed (Month, Day, Year) 10/04/00		
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) C.E. JENSEN MD, Box 690, DENTON MD 21629								
31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32432

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

OTIS COBB

2. Date of Death

Month Day Year

October 4 2000

3. Time of Death

2035

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

243-38-9732

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Mar. 22, 1922

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Caroline

10c. City, Town or Location

Preston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 63

10f. Zip Code

21655

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 41-4513. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Public Works/ Roads

16b. Kind of Business/Industry

Caroline County

17. Father's Name (First, Middle, Last)

Dock Cobb

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Bryant

19a. Informant's Name/Relationship (Type, Print)

Ida Louise Cobb/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 63, Preston, MD 21655

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Veterans Cemetery

Date

10/10

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

Michael J. Eskow

22. Name and Address of Facility

Frampton-Hawkins-Eskow Funeral Home, PA
PO Box 43, Federalsburg, Md 2163223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Dehydration with hypotension

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

one day

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. acute renal failure

Due to (or as a consequence of):

one day

c. severe COPD

Due to (or as a consequence of):

years

d. coronary artery disease

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending
investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Syed Ali

29c. License number

D46020

29d. Date signed (Month, Day, Year)

10/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed Ali, M.D. 506 Idlewild Ave., Easton, MD 21601

31. Date filed (Month, Day, Year)

OCT 6 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Otis Cobb

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32433

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Stanton Doyle				2. Date of Death Month Sept. 29, 2000 Year		3. Time of Death 6:44 a.m.	
	4e. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Williamsport		4c. County of Death Washington	
Funeral Director	5. Social Security Number 062-12-9712		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) March 20, 1919	
	10e. State W. Virginia		10b. County Jefferson		10c. City, Town or Location Harpers Ferry		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Quality Assurance Statistician		16b. Kind of Business/Industry U. S. Government				
17. Father's Name (First, Middle, Last) John Stanton Doyle				18. Mother's Name (First, Middle, Maiden Surname) Florence Barrett				
19e. Informant's Name/Relationship (Type, Print) Sandra J. Doyle Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 618 Harpers Ferry, W. Virginia 25425				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory		20c. Location - City or Town, State 10/2/00 Hagerstown, Maryland				
21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>				22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Arteriosclerotic cardiovascular disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Angiographic lateral sclerosis</i> <i>Hypertension</i> <i>Peripheral vascular disease</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D26806		29d. Date signed (Month, Day, Year) 09/29/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Arthur J. Sparks 747 North Me Harpers Ferry MD 21742</i>								
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Amended # 26

ACHD 10/3/00 MLV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32434

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ora Joe Darby

2. Date of Death
Month Day Year
September 30, 20003. Time of Death
10:50 PM

4a. Facility Name (If not institution, give street and number)

10013 Deist Lane, N.W.

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

234-52-6113

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

16-May-35

9. Birthplace (State or Foreign
Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10013 Deist Lane, N.W.

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Vietnam13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.Specify:
White15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housekeeping supervisor

16b. Kind of Business/Industry

hospital

17. Father's Name (First, Middle, Last)

Allan Darby

18. Mother's Name (First, Middle, Maiden Surname)

Tiida Carter

19a. Informant's Name/Relationship (Type, Print)

Nora "Kitty" Darby wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10013 Deist Lane, N.W. Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Frostburg Memorial Park

Date

04-Oct-00

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician
/Medical
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Exanguination

Due to (or as a consequence of):

12 hours

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Massive Gastrointestinal Bleeding

Due to (or as a consequence of):

12 hours

c. Severe Thrombocytopenia (Bone Marrow Transplant) 8 weeks

Due to (or as a consequence of):

d. Multiple Myeloma (Exposure to Agent Orange) 2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D13601

29d. Date signed (Month, Day, Year)

10/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V.R. Felipa, M.D., 925 Bishop Walsh Drive, Cumberland, Maryland 21502

State
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

SEP 20 1960

First Funeral Home, 57 First Ave., Frostburg, MD. 21532

04-Oct-00 Frostburg Maryland

10013 Deer Lane H.W. Frostburg Maryland 21532-

Ilida Carter

Housekeeping supervisor

Wife

U.S.A.

21532-

10013 Deer Lane, N.W.

Allegany

Frostburg

Maryland

10013 Deer Lane, N.W.

Frostburg

Allegany

10-May-32 West Virginia

224-25-6113

62

Old Joe Darry

September 30, 2000 10:30 AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32435

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard William Durst				2. Date of Death Month Day Year Sept 16 2000		3. Time of Death 10:30AM				
	4a. Facility Name (If not institution, give street and number) 12007 Bedford Road				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany				
Funeral Director	5. Social Security Number 182-01-6391		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs		8. Date of Birth (Month, Day, Year) April 19, 1910				
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland				
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 12007 Bedford RD. NE		10f. Zip Code 21502		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 4/1943 If Yes, Give Year or Dates: 11/1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) production line		16b. Kind of Business/Industry Tire industry							
17. Father's Name (First, Middle, Last) George Durst				18. Mother's Name (First, Middle, Maiden Surname) Sadie Mae (Brotemarkle) Durst							
19a. Informant's Name/Relationship (Type, Print) Virlen Stevens / sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 143 S. Water St., Frostburg, MD 21532							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Zion Memorial Park		Date 9/19/2000		20c. Location - City or Town, State Cumberland, MD					
21. Signature of Funeral Service Licensee Robert C. Adams				22. Name and Address of Facility Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Self inflicted gun shot wound to the chest Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death sudden									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 9/15/00		28b. Time of Injury ard 9:00PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject shot himself			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) residence		28f. Location (Street and Number or Rural Route Number, City or Town, State) 12007 Bedford Rd Cumb Md							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Paul Snow Dpty Medical Ex		29c. License number D09157		29d. Date signed (Month, Day, Year) Sept 16 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D. 124 W 3rd ST Cumb MD 21502											
31. Data filed (Month, Day, Year) SEP 16 2000		32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0020

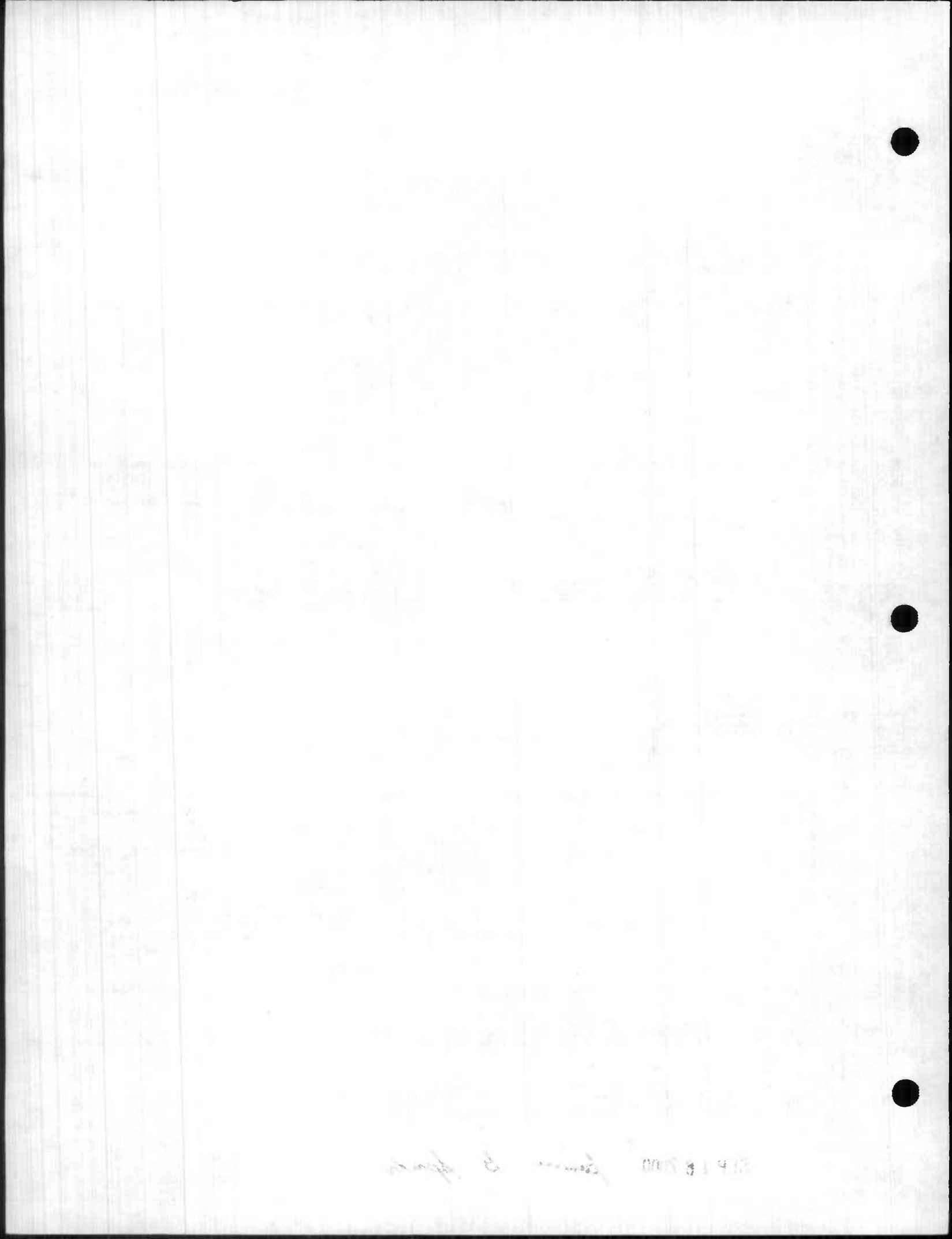
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Amended #4a, n28,
9/29/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

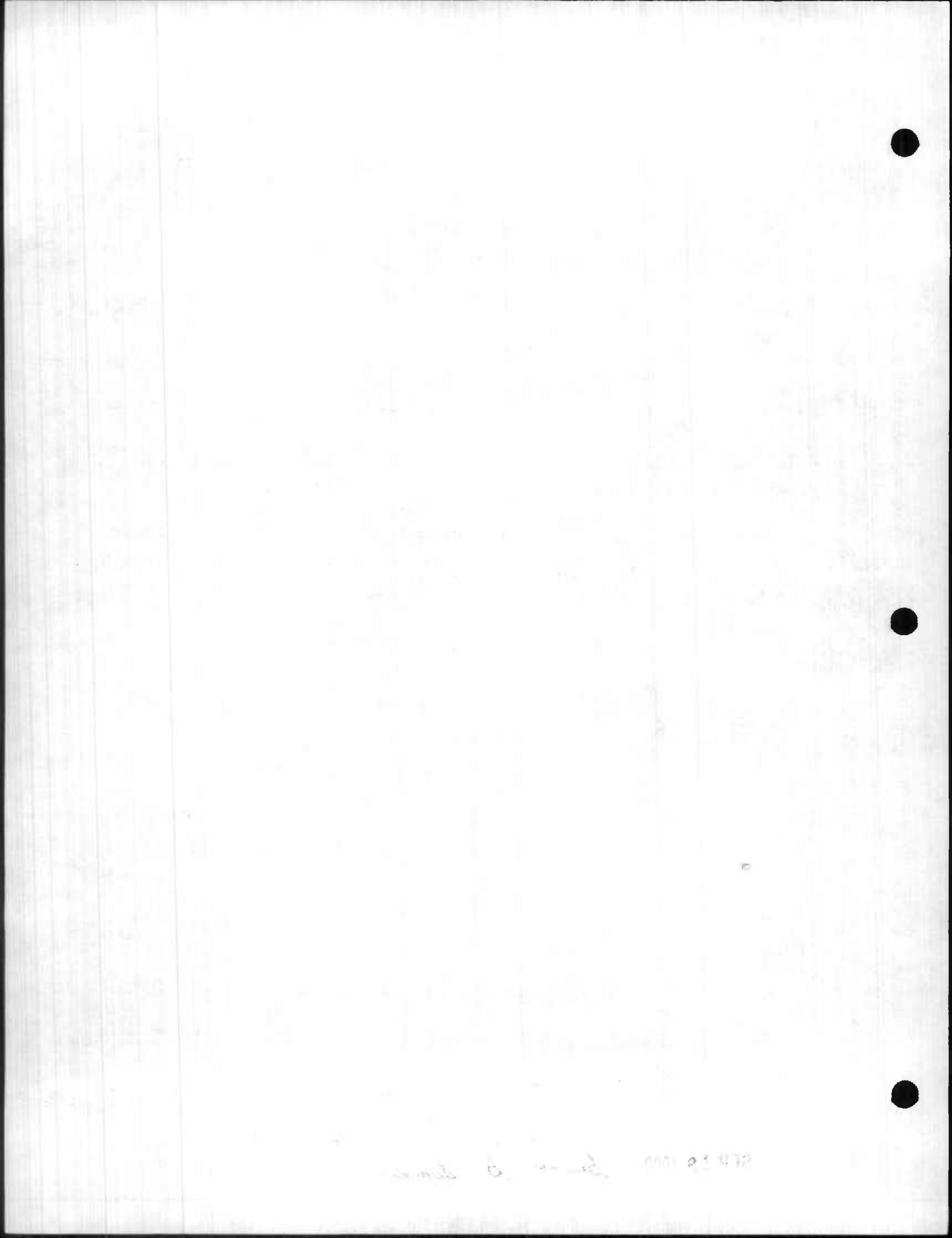
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32436

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard W English				2. Date of Death Month Day Year Sept. 26, 2000		3. Time of Death 11:06 pm	
	4a. Facility Name (If not institution, give street and number) 31 Richardson Way				4b. City, Town, or Location of Death LaVale		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 164-26-4852		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) June 20, 1932	
	9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Allegany		10c. City, Town or Location LaVale	
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 31 Richard Way		10f. Zip Code 21502		
10g. Citizen of What Country? USA		11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elevator Mechanic		16b. Kind of Business/Industry Elevator Company		
17. Father's Name (First, Middle, Last) Paul Leo English				18. Mother's Name (First, Middle, Maiden Surname) Florence Marie (Neibauer)				
19a. Informant's Name/Relationship (Type, Print) Margaret Bevan--sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Richard Way; LaVale, MD 21502				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mellinger Mennonite Cem		20c. Date 9/30/2000		20d. Location - City or Town, State Lancaster, PA		
21. Signature of Funeral Service Licensee James F Scarpelli		22. Name and Address of Facility Scarpelli Funeral Home, P.A. for Gundel FH Cumberland, MD 21502						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. End-stage Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 1 yr		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Gary Wagoner MD		29c. License number D22181		29d. Date signed (Month, Day, Year) Sept 27, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary Wagoner, M.D. Bishop Walsh Drive Cumberland MD 21502								
31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature James B Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32437

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Fink

2. Date of Death

9/24/2000

3. Time of Death

6:20AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

HCR/Manor Care

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

217-10-6898

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan 24, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1510 Providence Road

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Isaac F. Knick

18. Mother's Name (First, Middle, Maiden Surname)

Aletha B (Mowbray)

19a. Informant's Name/Relationship (Type, Print)

Ronald H. Athey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1510 Providence Road; Towson MD 21286

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sunset Memorial Park

Date

9/27/

2000

20c. Location - City or Town, State

Cumberland, MD

21. Signature of Funeral Service Licensee

James F. Scarpelli

Scarpelli Funeral Home, P.A.

Cumberland, MD 21502

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Ischemic Heart Disease

Approximate Interval Between Onset and Death

unknown years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Chronic Obstruction Heart Disease
degeneration arterioles

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James F. Scarpelli

29c. License number

D08358

29d. Date signed (Month, Day, Year)

SEPT 28 2,000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8903 HARTFORD HOSPITAL ROAD BALT. MD 21234

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

James F. Scarpelli

State
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

SEP 5 2 50PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32438

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES E. FRANK SR				2. Date of Death Month SEP Day 30 Year 2000		3. Time of Death 16:25H	
	4a. Facility Name (If not institution, give street and number) CHARLOTTE HALL VETERANS' HOME				4b. City, Town, or Location of Death CHARLOTTE HALL		4c. County of Death ST MARY'S	
Funeral Director	5. Social Security Number 577-07-3495		6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 29 1915	9. Birthplace (State or Foreign Country) Washington, DC
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County St Mary's		10c. City, Town or Location Charlotte Hall		10d. Inside City Limits 1 Yes 2 No	
	10e. Street and Number 29449 Charlotte Hall Road				10f. Zip Code 20662		10g. Citizen of What Country? USA	
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver				16b. Kind of Business/Industry Public Transportation	
	17. Father's Name (First, Middle, Last) Jacob H. Frank				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Miller Frank			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Judith A. Herndon (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26926 Tin Top School Rd Mechanicsville, MD 20659			
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		Date 10-4-00		20c. Location - City or Town, State Waldorf, MD	
	21. Signature of Funeral Service Licensee [Signature]		M00173		22. Name and Address of Facility Eberwein Funeral Services 4433 White Pls La White Pls., MD 20695			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death							
	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DIABETES MELLITUS, ATRIAL FIBRILLATION, DEMENTIA, DEPRESSION, CORONARY ARTERY DISEASE								
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D50963		29d. Date signed (Month, Day, Year) 09/20/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHVH, 29449 CHARLOTTE HALL RD., CHARLOTTE HALL, MD 20622								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32439

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sara Elizabeth Guild				2. Date of Death Month Day Year September 29 2000				3. Time of Death 3:45AM	
	4a. Facility Name (If not institution, give street and number) Clearview Nursing Home				4b. City, Town, or Location of Death Hagerstown				4c. County of Death Washington	
Funeral Director	5. Social Security Number 212-07-8264		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) October 27, 1912		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 9946 Downsville Pike		10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner and Operator				16b. Kind of Business/Industry Delicatessen	
	17. Father's Name (First, Middle, Last) David Earl Neikirk				18. Mother's Name (First, Middle, Maiden Surname) Margaret Estella Hoover					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) David L. Marsee				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 Nelson Avenue, Manhattan Beach, CA. 90266					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery 10-02-2000 Hagerstown, Maryland		20c. Location - City or Town, State					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee R. Noel Brady				22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Acute Bronchial Pneumonia Due to (or as a consequence of): Cancer of Lung Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 3 days 6 months					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old Cerebral Infarction with Aphasia and left Hemiparesis Hypertension				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Edson B. Moody M.D.		29c. License number D07857		29d. Date signed (Month, Day, Year) September 29, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edson B. Moody M.D. 1190 Mt. Aetna Road, Hagerstown, Md. 21740				31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature Benita Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32440

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER MOSES GROSS

2. Date of Death

September 27, 2000 4:10 P.M.

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

408 North Mechanic Street

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

217-10-7464

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 6 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

408 NORTH MECHANIC STREET

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

OWNER/OPERATOR GROSS BROTHERS PLUMBING/HEATING

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

SOLOMON GROSS

18. Mother's Name (First, Middle, Maiden Surname)

LEOTA HIMMLER

19a. Informant's Name/Relationship (Type, Print)

ROBERT A. GROSS BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

408 NORTH MECHANIC STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLCREST CEMETERY OCTOBER 3 2000 CUMBERLAND MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dale L. Merritt

22. Name and Address of Facility

MERRITT-ADAMS FUNERAL HOME P.A.

404 DECATUR STREET CUMBERLAND MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Dennis J. Chute

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Map of ...

Handwritten text, possibly a signature or date, located at the bottom center of the page.

0005 0 0 0 12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32442

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence Randolph Gillen					2. Date of Death Month Day Year SEPTEMBER 22, 2000		3. Time of Death 9:20 PM	
	4a. Facility Name (If not institution, give street and number) VA MARYLAND HEALTH CARE SYSTEM					4b. City, Town, or Location of Death PERRY POINT		4c. County of Death CECIL	
Funeral Director	5. Social Security Number 214-07-8334	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 18, 1915		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Cambridge			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6033 Corners Wharf Road				10f. Zip Code 21613		10g. Citizen of What Country? US			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant		16b. Kind of Business/Industry Food Processing			
17. Father's Name (First, Middle, Last) Oliver Putnam					18. Mother's Name (First, Middle, Maiden Surname) Edna Mae Dix				
19a. Informant's Name/Relationship (Type, Print) Charlotte A. Lewis Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6033 Corners Wharf Road Cambridge, Maryland 21613					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Dorchester Memorial Park		Date 9/26/00		20c. Location - City or Town, State Cambridge, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. UNKNOWN Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY BIPASS GRAFT HYPERTENSION DEGENERATIVE JOINT DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier  MELECIA SANTOS, M.D.				29c. License number 151094-1		29d. Date signed (Month, Day, Year) SEPTEMBER 22, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELECIA SANTOS, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902									
State Registrar		31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN:

LAWRENCE GILLEN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SEP 8 1952

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32443

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES GROSS

2. Date of Death
Month Day Year

SEPT. 24 2000

3. Time of Death

1733

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral
Director

5. Social Security Number

216-16-4596

6. Sex
☒ M ☐ F

7. Age (In yrs. last birthday)

91

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

FEB. 21 1909

9. Birthplace (State or Foreign
Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

10c. City, Town or Location

LOTHIAN

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5025 SOLOMONS ISLAND ROAD

10f. Zip Code

20711

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SHARE CROPPER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

MALCOM GROSS

18. Mother's Name (First, Middle, Maiden Surname)

SUSAN PINDELL

19a. Informant's Name/Relationship (Type, Print)

AGNES PINKNEY (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5025 SOLOMONS ISLAND RD. LOTHIAN, MD.

20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MT. ZION CHURCH CEME. 9/29/00 LOTHIAN, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Harry D. Reese MD00482

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and Title of Certifier

Charles W. Phelps MD

29c. License number

D41816

29d. Date signed (Month, Day, Year)

9/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles W. Phelps MD

Anne Arundel Medical Center

64 Franklin St.
Annapolis, MD 21401State
Registrar

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

B. B. B.

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

mcg

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32444

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE MARIE HAYNES						2. Date of Death Month Day Year September 26 2000		3. Time of Death 1825		
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL						4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON		
Funeral Director	5. Social Security Number 219-20-2332		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) MAY 8, 1921		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MARYLAND			10b. County WASHINGTON			10c. City, Town or Location BOONSBORO			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 120 LAKIN AVENUE						10f. Zip Code 21713		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ACCOUNTANT				16b. Kind of Business/Industry AIRCRAFT MANUFACTURING			
17. Father's Name (First, Middle, Last) DANIEL E. NICODEMUS						18. Mother's Name (First, Middle, Maiden Surname) ANNA I. SINNISEN					
19a. Informant's Name/Relationship (Type, Print) GLENN C. HAYNES/SPOUSE						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 LAKIN AVENUE, BOONSBORO, MARYLAND 21713					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) BOONSBORO CEMETERY			Date 9/29/00		20c. Location - City or Town, State BOONSBORO, MARYLAND			
21. Signature of Funeral Service Licensee  Paul M. Dean			22. Name and Address of Facility BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Heart Failure Due to (or as a consequence of): Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Arteriosclerotic Cardiovascular Disease Diabetes Mellitus										Approximate Interval Between Onset and Death 2-3 days 3 yrs	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Cardiovascular Disease Diabetes Mellitus										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier 	
29c. License number 018019						29d. Date signed (Month, Day, Year) Sept 27, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Datta 334 Mill St. Hager, Md 21740											
31. Date filed (Month, Day, Year) SEP 28 2000			32. Registrar's Signature 								

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32445

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ray Alfred Hott Sr.

2. Date of Death

Month 9 Day 27 Year 2000

3. Time of Death

3:17 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Memorial Hospital & Medical Center

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

215-26-6871

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

May 7, 1923

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

PA

10b. County

Bedford

10c. City, Town or Location

Hyndman

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1907 Cooks Mill Road

10f. Zip Code

15545

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Date

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Carpentry

17. Father's Name (First, Middle, Last)

Samuel Walker Hott

18. Mother's Name (First, Middle, Maiden Surname)

Anna L (Wilson)

19a. Informant's Name/Relationship (Type, Print)

Linda McMannis

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1907 Cooks Mill Road; Hyndman PA 15545

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial Gard 2000

Date

10/02

20c. Location - City or Town, State

LaVale, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home, P.A.
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

PNEUMONIA

Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE LUNG DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vik Poonai

29c. License number

D36766

29d. Date signed (Month, Day, Year)

September 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. VIK POONAI 920 NATIONAL HIGHWAY LAVALE, MD 21502

State
Registrar

31. Date (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

Vik Poonai

RAY HOTT 215-26-6871

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

James P. Moore

SEP 20 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32446

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Martha E. Hewitt

2. Date of Death

Month Day Year
October 3, 2000

3. Time of Death

1640

4a. Facility Name (If not institution, give street and number)

Sacred Heart Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

219-52-0401

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
12-Dec-21

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

111 High Street

10f. Zip Code

21532-1624

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dietary Supervisor

16b. Kind of Business/Industry

Food Industry

17. Father's Name (First, Middle, Last)

Arthur Robison

18. Mother's Name (First, Middle, Maiden Surname)

Lucy E. Morris

19a. Informant's Name/Relationship (Type, Print)

Richard Hewitt husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 High Street Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Saint Michael's Cemetery

Date

06-Oct-00

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee

John R. Durst

22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic INFLAMMATORY Bowel Disease (or as a consequence of:)
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

48 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, History of
Renal Cell Carcinoma, Chronic
Artery Disease, Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert Welik

29c. License number

D31875

29d. Date signed (Month, Day, Year)

October 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Welik M.D. 902 Seton Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

OCT 05 2000

32. Registrar's Signature

Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3/4

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32447

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Zones Hall		2. Date of Death Month: OCTOBER Day: 5 Year: 2000		3. Time of Death 2:30 AM
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany
Funeral Director	5. Social Security Number 215-26-9816	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months: Days: Hours: Min.	8. Date of Birth (Month, Day, Year) Jun 12, 1924
	9. Birthplace (State or Foreign Country) WV				
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. State MD	10b. County Garrett	10c. City, Town or Location Friendsville		
	10e. Street and Number 934 Second Avenue		10f. Zip Code 21531		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Date: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) laborer		16b. Kind of Business/Industry Orchard Company
	17. Father's Name (First, Middle, Last) Arnold Hall		18. Mother's Name (First, Middle, Maiden Surname) Lettie (Goldison)		
	19e. Informant's Name/Relationship (Type, Print) Allen Hall		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Applewood Drive; LaVale MD 21502		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cem 2000		20c. Location - City or Town, State Flintstone, MD
	21. Signature of Funeral Service Licensee James F. Scarpelli		22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOPATHY Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
Approximate Interval Between Onset and Death 1 YEAR 2 YEARS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 29c. License number D 36766 29d. Date signed (Month, Day, Year) October 5, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIK POONAI, 920 NATIONAL HIGHWAY, LAVALE, MARYLAND 21502					
31. Date (Month, Day, Year) OCT 05 2000 32. Registrar's Signature [Signature]					

ZONES HALL 215-26-9816
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten signature or initials

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

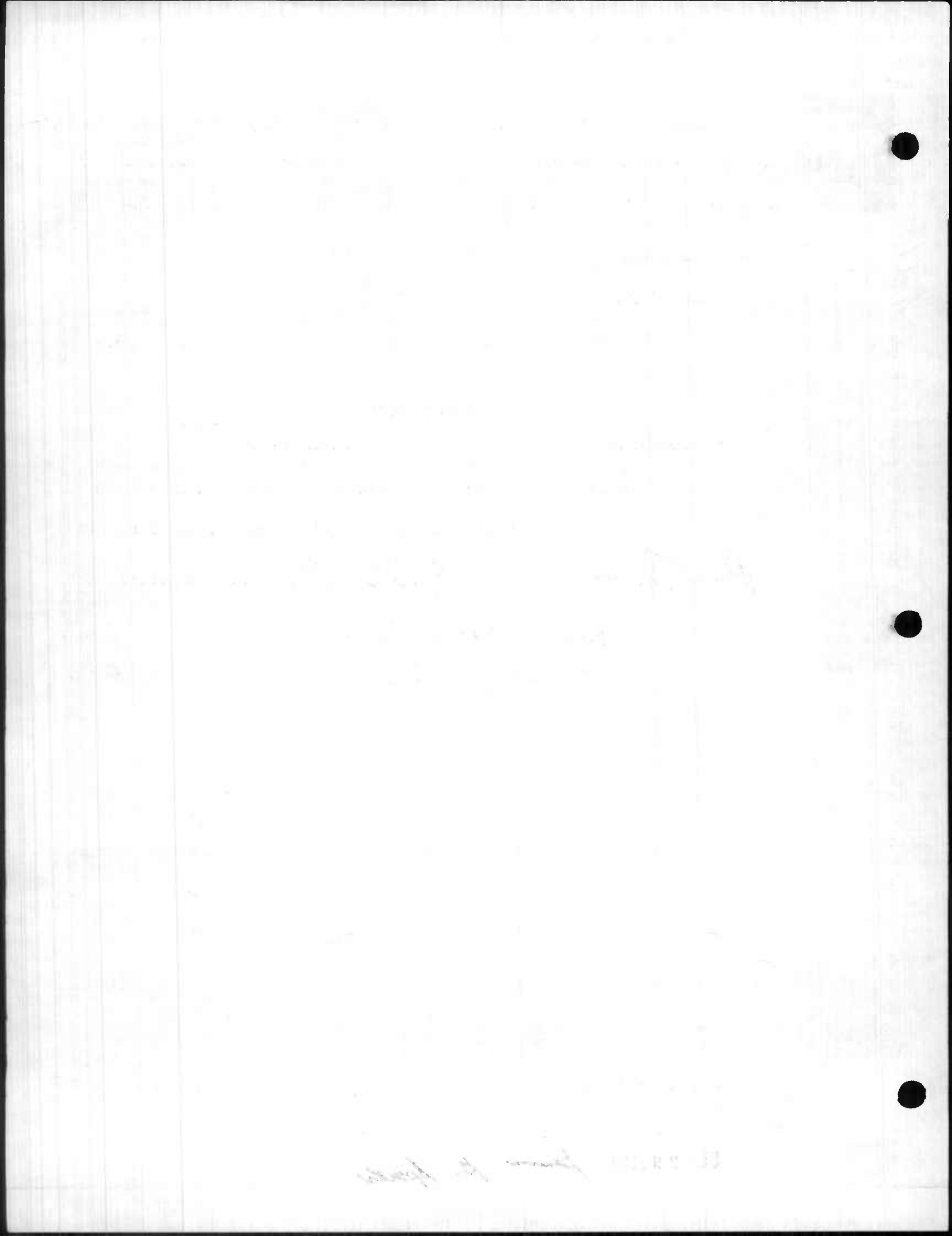
State of Maryland / Department of Health and Mental Hygiene

00 32448

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edwin Peters Hunsicker				2. Date of Death Month Sept Day 28 Year 2000		3. Time of Death 12:10 pm	
	4a. Facility Name (If not institution, give street and number) Chesapeake Woods Center				4b. City, Town, or Location of Death Cambridge		4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 165-16-7570		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Sept 5, 1920	
	Usual Residence of Decedent 10a. State Maryland 10b. County Dorchester		10c. City, Town or Location Cambridge		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		9. Birthplace (State or Foreign Country) Pennsylvania	
To Be Completed by Funeral Director	10e. Street and Number 525 Glenburn Avenue		10f. Zip Code 21613		10g. Citizen of What Country? US		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Letter Carrier		16b. Kind of Business/Industry Postal Service		17. Father's Name (First, Middle, Last) Stanley Hunsicker		18. Mother's Name (First, Middle, Maiden Surname) Eva M. Peters	
	19a. Informant's Name/Relationship (Type, Print) Kathy Counts Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Somerset Avenue Cambridge, Maryland 21613		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Memorial Park	
	20c. Date 10/2/00		20d. Location - City or Town, State Hanover TWP. PA		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613	
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Renal Cell Cancer Due to (or as a consequence of): b. Generalized Asepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 6 mo 2 yr		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
	29c. License number D263886		29d. Date signed (Month, Day, Year) Sept 28, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Fadden 302 Collins Harlock Md 21643		31. Data filed (Month, Day, Year) SEP 29 2000	
32. Registrar's Signature 		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32449

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRY HOMER JONES						2. Date of Death Month Day Year OCTOBER 2 2000		3. Time of Death 9:00 PM	
	4e. Facility Name (If not institution, give street and number) GOODWILL MENNONITE HOME						4b. City, Town, or Location of Death GRANTSVILLE		4c. County of Death GARRETT	
Funeral Director	5. Social Security Number 217-10-1662		6. Sex M F M		7. Age (in yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) OCTOBER 5 1919		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 13505 BRISTOL DRIVE S.W.				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1944		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) KELLY SPRINGFIELD TIRE CO.			16b. Kind of Business/Industry TIRE MANUF.		
	17. Father's Name (First, Middle, Last) JOHN DAVID JONES						18. Mother's Name (First, Middle, Maiden Surname) ALVERNA ELLEN McBRIDE			
	19a. Informant's Name/Relationship (Type, Print) DARLENE RECKLEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAUGHTER 7595 JENN DRIVE WOODBINE, MARYLAND 21797					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY		Date OCTOBER 5, 2000		20c. Location - City or Town, State CUMBERLAND MARYLAND	
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. <i>Respiratory Failure</i> Due to (or as a consequence of): b. <i>Pneumonia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Artery Disease</i> <i>Multi-Infarct Dementia</i>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <i>Elvin L. Martin MD</i>				29c. License number H0014528		29d. Date signed (Month, Day, Year) 10/3/2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Elvin L. Martin MD Meyersdale, Pa. 15552</i>									
	31. Date filed (Month, Day, Year) OCT 04 2000 32. Registrar's Signature <i>Sparks</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

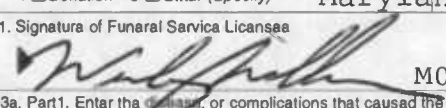
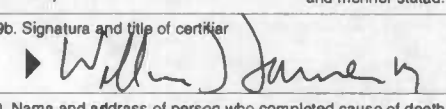
State of Maryland / Department of Health and Mental Hygiene

00 32450

Amended Item#5 per FHG789 11/13/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Gibbons Johnson				2. Date of Death Month Day Year October 2, 2000				3. Time of Death 4:00 pm	
	4a. Facility Name (If not institution, give street and number) 6764 Amherst Road				4b. City, Town, or Location of Death Bryans Road				4c. County of Death Charles	
Funeral Director	5. Social Security Number 577-05-2815		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 10-05-1915		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent				10a. State Maryland		10b. County Charles		10c. City, Town or Location Bryans Road	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 6764 Amherst Road		10f. Zip Code 20616		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		16b. Kind of Business/Industry Liquor Store			
	17. Father's Name (First, Middle, Last) Thomas Hardy Johnson				18. Mother's Name (First, Middle, Maiden Surname) Marie Harris					
	19a. Informant's Name/Relationship (Type, Print) Thomas K. Johnson/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2114 Marshall Hall Road, Bryans Road, Maryland 20616					
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 10-10-2000		20c. Location - City or Town, State Cheltenham, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Williams Funeral Home, P.A. 20640 4270 Hawthorne Road, Indian Head, Maryland					
	23a. Part I. Enter the condition, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. prostate cancer b. colon cancer c. d.				Approximate Interval Between Onset and Death 1 1/2 yrs. 1 1/2 yrs.					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D35206		29d. Date signed (Month, Day, Year) October 3, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Towler MD 11201 Loughboro Rd. Fort Washington, MD									
	31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32451

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MYRTLE MAE KESNER		2. Date of Death Month: OCTOBER Day: 4 Year: 2000		3. Time of Death 16:30
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center		4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany
Funeral Director	5. Social Security Number 215-20-6325	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) MAY 1, 1924		9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent					
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 224 GLENN STREET APT 1		10f. Zip Code 21502		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: WHITE					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DOWN TWISTER		16b. Kind of Business/Industry FIBER/TEXTILE MANUFACTURING	
17. Father's Name (First, Middle, Last) LOUIS LARK			18. Mother's Name (First, Middle, Maiden Surname) ELLA UNKNOWN		
19a. Informant's Name/Relationship (Type, Print) NORMA HUTSON - DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12328 SHADOE HOLLOW RD NE, CUMBERLAND, MD 21502		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) REST LAWN MEMORIAL GARDENS		20c. Location - City or Town, State, Zip Code LAVALE, MD 21502	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility HAFFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): b. RENAL FAILURE Due to (or as a consequence of): c. ANEMIA Due to (or as a consequence of): d.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D36766		29d. Date signed (Month, Day, Year) October 5, 2000	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) VIK POONAI, 920 NATIONAL HIGHWAY, LAVALE, MD 21502					
31. Date filed (Month, Day, Year) OCT 05 2000		32. Registrar's Signature 			

MYRTLE KESNER 215-20-6325
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten text, possibly a signature or date, located at the bottom center of the page.

0001 30 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32452

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence Clair Kling, Sr.				2. Date of Death Month October Day 3 Year 2000		3. Time of Death 2350	
	4a. Facility Name (If not institution, give street and number) 21840 Water Street				4b. City, Town, or Location of Death Preston		4c. County of Death Caroline	
Funeral Director	5. Social Security Number 159-16-0489		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06/17/19	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Caroline	10c. City, Town or Location Preston			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 21840 Water Street				10f. Zip Code 21655		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 40-70		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sgt. Major USMC		16b. Kind of Business/Industry Marine Corps			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Lawrence Clay Kling				18. Mother's Name (First, Middle, Maiden Surname) Linnie Siegfried			
	19a. Informant's Name/Relationship (Type, Print) Millicent Maloney/Att.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 W. Central Ave., Federalsburg, MD 21632			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Natl. Cem.		20c. Location - City or Town, State 10/10 Quantico, Virginia			
	21. Signature of Funeral Service Licensee Michael J. Eskow				22. Name and Address of Facility Frampton-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632			
Physician /Medical Examiner	23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Metastatic Rectal Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 1-2 DAYS 2 months
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier Gerard Fumo				29c. License number H0056042		29d. Date signed (Month, Day, Year) 10/04/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerard Fumo, DO, National Navy Medical Center Bethesda MD							
	31. Date filed (Month, Day, Year) OCT 06 2000				32. Registrar's Signature B. Spaw			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

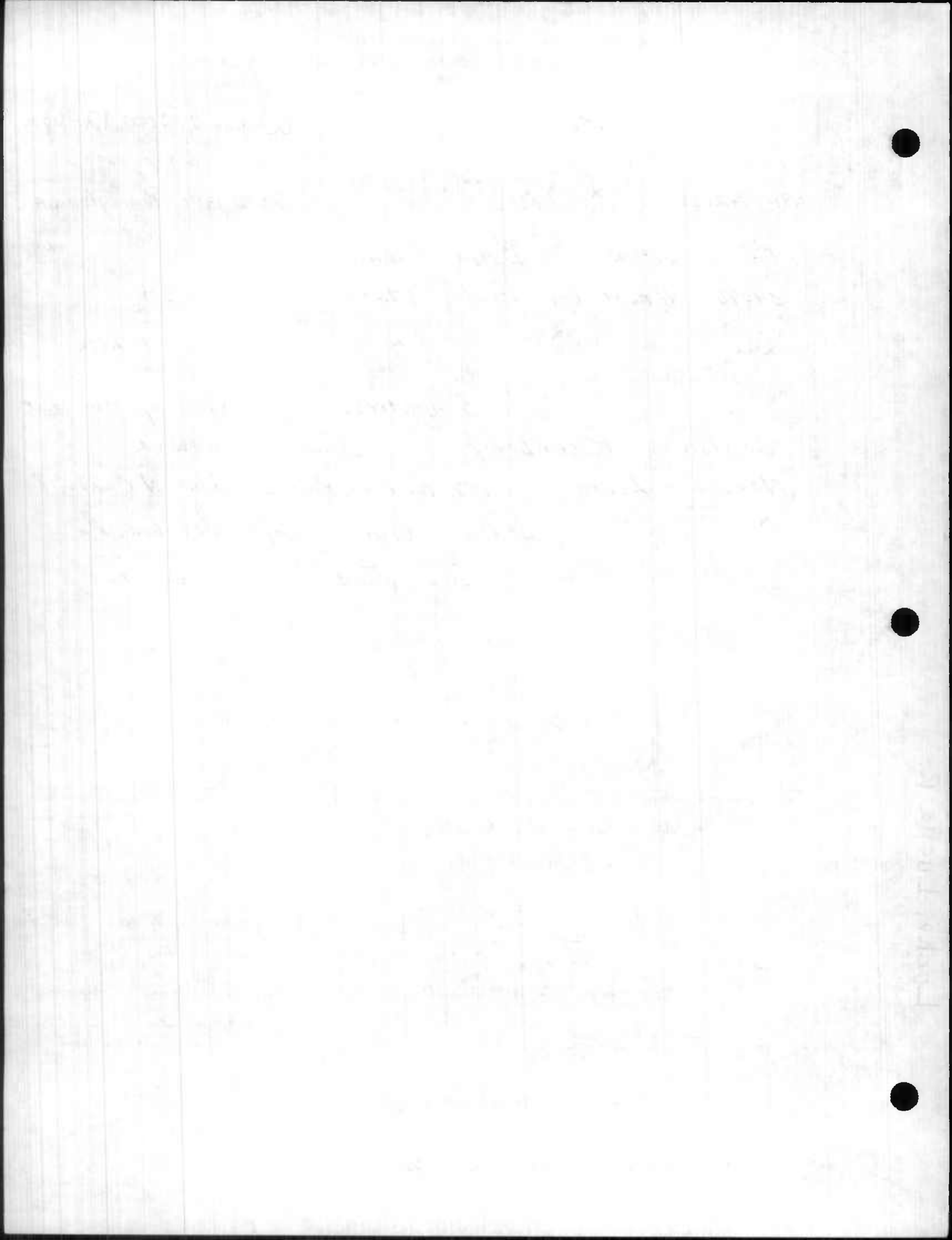
State of Maryland / Department of Health and Mental Hygiene

00 32453

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LUELLA R LOCKE				2. Date of Death Month October Day 2 Year 2000		3. Time of Death 12:46pm	
	4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				4b. City, Town, or Location of Death HAGERSTOWN		4c. County of Death WASHINGTON	
Funeral Director	5. Social Security Number 181-07-2138		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) OCT 7, 1919	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State PA		10b. County FULTON		10c. City, Town or Location Burnt Cabins	
Usual Residence of Decedent		10e. Street and Number 34096 GREENT COVE ROAD		10f. Zip Code 17215		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress		16b. Kind of Business/Industry Clothing Manufact.				
17. Father's Name (First, Middle, Last) Denton Rosenberry				18. Mother's Name (First, Middle, Maiden Surname) JANE WARNICK				
19a. Informant's Name/Relationship (Type, Print) NORMAN LOCKE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1358 N. Fork Road, Zionsville N.C. 28698				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bt. Cabins Cem.		20c. Location - City or Town, State 10/4/00 Bt. Cabins, Pa.		20d. Date		
21. Signature of Funeral Service Licensee James A. Brown				22. Name and Address of Facility Grove - Bowersox Funeral Home Inc 503 Broad St., Waynesboro PA				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. BRAINSTEM STROKE Due to (or as a consequence of): b. HEMORRHAGIC CEREBRAL METASTATIC DISEASE Due to (or as a consequence of): c. DIFFUSE SUBARACHNOID HEMORRHAGE Due to (or as a consequence of): d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF COLON CANCER								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier James A. Brown STATE MEDICAL EXAMINER		29c. License number 051043		29d. Date signed (Month, Day, Year) 10/2/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JCARUSO MD 1110 MEDICAL CAMPUS RD SUITE 127 HAGERSTOWN MD 21742								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature Denise B Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32454

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FLOYD KENNETH MINNICK, SR.				2. Date of Death Month Day Year September 27, 2000		3. Time of Death 7:54 PM	
	4a. Facility Name (If not institution, give street and number) Julia Manor Nursing Home				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington County	
Funeral Director	5. Social Security Number 217-18-7117		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 7, 1919	
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State MD		10b. County Washington		10c. City, Town or Location Hagerstown	
Usual Residence of Decedent								
10a. State MD				10b. County Washington		10c. City, Town or Location Hagerstown		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 18448 Woodside Drive				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance			16b. Kind of Business/Industry Board of Education	
17. Father's Name (First, Middle, Last) Harvey Nelson Minnick, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna Shafer				
19a. Informant's Name/Relationship (Type, Print) Marvene Alicia Minnick/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18448 Woodside Drive, Hagerstown, Maryland 21740				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Blairs Valley Cemetery		20c. Date Sept. 30		20d. Location - City or Town, State Clear Spring, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742				
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Renal Failure Due to (or as a consequence of): b. cerebrovascular Accident Due to (or as a consequence of): c. Prostate carcinoma Due to (or as a consequence of): d. COPD Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION H/o Myocardial Infarction I.V.D								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number 052323			29d. Date signed (Month, Day, Year) 09/29/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHALID WASSEM, 333 Mill Street, Hagerstown, Maryland 21740								
31. Date filed (Month, Day, Year) OCT 02 2000			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32455

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roger Lee Mort				2. Date of Death Month Day Year October 2 2000				3. Time of Death 5:23 PM	
	4a. Facility Name (If not institution, give street and number) 38 North Conococheague Street				4b. City, Town, or Location of Death Williamsport				4c. County of Death Washington	
Funeral Director	5. Social Security Number 220-64-6748		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1952		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Washington		10c. City, Town or Location Williamsport	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 38 North Conococheague Street				10f. Zip Code 21795	
	10g. Citizen of What Country? USA				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Equipment Operator				16b. Kind of Business/Industry Municipality				17. Father's Name (First, Middle, Last) Paul Mort, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Timmons				19a. Informant's Name/Relationship (Type, Print) Linda Reed/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Liganore Avenue Hagerstown, Maryland 21740	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Memorial Park				20c. Location - City or Town, State 10-5-00 Williamsport, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier  M.D.				29c. License number D-56413				29d. Date signed (Month, Day, Year) 10/04/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanjay Saxena, M.D. 3 Byrkit Drive Williamsport, MD				31. Date filed (Month, Day, Year) OCT 04 2000				32. Registrar's Signature  B. Sparks 21795		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32456

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARVEY JUNIOR MILLER				2. Date of Death Month October Day 3 Year 2000		3. Time of Death 1259										
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington										
Funeral Director	5. Social Security Number 220 16 0350		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Feb 15 1918										
	9. Birthplace (State or Foreign Country) Greensburg, MD		10a. State MD		10b. County Washington		10c. City, Town or Location Smithsburg										
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10a. Street and Number 13331 Greensburg Rd		10f. Zip Code 21783		10g. Citizen of What Country? USA										
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farming												
	17. Father's Name (First, Middle, Last) Mahlon H. Miller				18. Mother's Name (First, Middle, Maiden Surname) Mary E Kinsey												
	19a. Informant's Name/Relationship (Type, Print) Marquise A Miller, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13331 Greensburg Rd Smithsburg Md 21783												
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wetly Church Cemetery		20c. Date Oct 5		20d. Location - City or Town, State Washington Co MD										
	21. Signature of Funeral Service Licensee James A Bowersox				22. Name and Address of Facility Grove Bowersox Funeral Home 50 S Broad St Wyncboro Pa 17268												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Acute myocardial Infarction</td> <td>Approximate Interval Between Onset and Death 2 days</td> </tr> <tr> <td>b. Coronary Artery Disease</td> <td>years</td> </tr> <tr> <td>c. Cardiomyopathy</td> <td>years</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial Infarction	Approximate Interval Between Onset and Death 2 days	b. Coronary Artery Disease	years	c. Cardiomyopathy	years	d.	
	Immediate Cause (Final disease or condition resulting in death)	a. Acute myocardial Infarction	Approximate Interval Between Onset and Death 2 days														
b. Coronary Artery Disease		years															
c. Cardiomyopathy		years															
d.																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined																	
28a. Date of Injury (Month, Day Year) 11/10 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
28d. Describe how injury occurred																	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																	
28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier Dr. Haywood																	
29c. License number D 25714																	
29d. Date signed (Month, Day, Year) 10-4-00																	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Haywood 11110 medical Campus Rd Hager Md 21742																	
31. Date filed (Month, Day, Year) OCT 04 2000																	
32. Registrar's Signature Benita B Sparks																	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

February 11, 1900

My dear Mr. Brewster

I have just received your letter of the 10th inst. and am glad to hear from you. I am well and hope these few lines will find you the same.

I have been thinking much of late about the future of our country and the people who inhabit it. I feel that we are in a critical position and that the future of our country depends upon the wisdom and courage of the people who are now in power. I hope that you will be able to do something to help our country in this time of need.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32457

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert E. McKenzie

2. Date of Death
Month Day Year
September 30, 20003. Time of Death
01:25 PM

4a. Facility Name (If not Institution, give street and number)

205 McCulloh Street

4b. City, Town, or Location of Death

Frostburg

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

212-10-6264

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
16-Jan-16

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Allegany

10c. City, Town or Location

Frostburg

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

205 McCulloh Street

10f. Zip Code

21532-

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
8College (1-4 or 5+)
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Spinning Department

16b. Kind of Business/Industry

textile manufacturing

17. Father's Name (First, Middle, Last)

Edward Joseph McKenzie

18. Mother's Name (First, Middle, Maiden Surname)

Mary Freal

19a. Informant's Name/Relationship (Type, Print)

Irene McKenzie wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 McCulloh Street Frostburg Maryland 21532-

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Frostburg Memorial Park


Date

03-Oct-00

20c. Location - City or Town, State

Frostburg, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Carcinoma of the bladder

Due to (or as a consequence of):

5 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Chronic Obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0024951

29d. Date signed (Month, Day, Year)

October 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chang-Hyun Oh, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

State
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature



ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(144) mu 11

Chong-Hyun Oh, M.D., 48 Tam Jence, Hosiung, Waiyang 51235

SEP 20 1990

Handwritten signature

Quint Funeral Home, 57 East Ave., Hosiung, MD 51235

03-04-00 Hosiung, Waiyang

302 McCullin Street

Hosiung, Waiyang

51235

Wife

Edward Joseph McKenzie

May 1961

Spinning Department

with a truck

White

U.S.A.

51235-

Hosiung

302 McCullin Street

Allegany

Waiyang

84

512-10-0341

302 McCullin Street

Hosiung

Allegany

September 20, 2000

01:25 PM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32458

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Francis McGowan				2. Date of Death Month Day Year October 02, 2000				3. Time of Death 10:25 PM	
	4a. Facility Name (If not institution, give street and number) 19603 Old Dans Rock Road, S.W.				4b. City, Town, or Location of Death Frostburg				4c. County of Death Allegany	
Funeral Director	5. Social Security Number 218-38-0213		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) 01-Aug-41		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Allegany		10c. City, Town or Location Frostburg				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 19603 Old Dans Rock Road, S.W.				10f. Zip Code 21532-				10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1960-62		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barrack Commander				16b. Kind of Business/Industry state police	
	17. Father's Name (First, Middle, Last) John Leo McGowan				18. Mother's Name (First, Middle, Maiden Surname) Rose Mary Urbas					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Charlotte McGowan wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19603 Old Dans Rock Road, Frostburg Maryland 21532-					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Saint Michael's Cemetery		Date 06-Oct-00		20c. Location - City or Town, State Frostburg, Maryland	
	21. Signature of Funeral Service Licensee <i>John Durst</i>				22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cholangiocarcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 year									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Esophagitis									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Jose I. Lovera MD</i>				29c. License number D12532	
	29d. Date signed (Month, Day, Year) 4 Oct 2000									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jose I. Lovera, M.D., 912 Seton Drive, Cumberland, Maryland 21502									
31. Date (Month, Day, Year) OCT 05 2000										
32. Registrar's Signature <i>Benjamin B. Sparks</i>										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

John Francis McGowan 10331W October 03 2000

218-28-0313 1903 Old Darr Road, 2.W. Allegany Maryland 21235-01-Aug-41 Maryland

1903 Old Darr Road, 2.W. Allegany Maryland 21235-01-Aug-41 U.S.A. White

12 3 Barrack Commander from Darr

John Leo McGowan Charlotte McGowan wife 1903 Old Darr Road, Frostburg Maryland 21235-01-Aug-41

John McGowan Cemetery 06-Oct-00 Frostburg, Maryland

Darr Funeral Home, 27 First Ave., Frostburg, MD 21235

John T. Lavan, M.D., 212 Seton Drive, Cumberland, Maryland 21202

John T. Lavan, M.D., 212 Seton Drive, Cumberland, Maryland 21202

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32459

amend item 8 per fh G788 10/23/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James Charles McCoy</i>				2. Date of Death Month <i>Sept.</i> Day <i>23</i> Year <i>2000</i>				3. Time of Death <i>1:47pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>520 Evergreen Road</i>				4b. City, Town, or Location of Death <i>Severna Park</i>				4c. County of Death <i>Anne Arundel</i>	
Funeral Director	5. Social Security Number <i>264-44-4458</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>67</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Sept. 16, 1933</i>		9. Birthplace (State or Foreign Country) <i>CA</i>	
	Usual Residence of Decedent									
10a. State <i>MD</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Severna Park</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <i>520 Evergreen Road</i>				10f. Zip Code <i>21146</i>			10g. Citizen of What Country? <i>USA</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>Korea</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <i>5+</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Electronic Engineer</i>			16b. Kind of Business/Industry <i>Engineering</i>			
17. Father's Name (First, Middle, Last) <i>James C. McCoy, Sr.</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Alma Gay</i>					
19a. Informant's Name/Relationship (Type, Print) <i>James C. McCoy, III/Son</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P.O. Box 904, Londonderry, NH 03053</i>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		Date <i>Sept 26 2000</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>			
21. Signature of Funeral Service Licensee <i>James E. Barranco</i>					22. Name and Address of Facility <i>Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146</i>					
23a. Part I. Briefly list the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>a. coronary artery disease</i> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d.</i>										Approximate Interval Between Onset and Death <i>years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was care referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Jeffrey Briggs MD</i>					29c. License number <i>D28640</i>			29d. Date signed (Month, Day, Year) <i>Sept. 24, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jeffrey Briggs, MD, 2414 Hightee Court, Crofton, MD 21114</i>										
State Registrar		31. Date filed (Month, Day, Year) <i>SEP 28 2000</i>		32. Registrar's Signature <i>James P. Jones</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint handwritten marks]

0005 8 S 932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32460

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Kirk Morris

2. Date of Death
Month Day Year
SEPTEMBER 24, 20003. Time of Death
4:08AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral
Director

5. Social Security Number

003-22-2790

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept. 2, 1919

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

711 Ballast Way

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)
4 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Charles Whitfield Morris

18. Mother's Name (First, Middle, Maiden Surname)

Celia Marie Kirk

19a. Informant's Name/Relationship (Type, Print)

Eileen Morris/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

711 Ballast Way Annapolis, Maryland 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat'l. Cem.

Date

10-3-00

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home
2973 Solomons Island Rd. Edgewater, MD 21037

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

7 DAYS

Due to (or as a consequence of):

b. ALZHEIMER'S DEMENTIA

9 MONTHS

Due to (or as a consequence of):

c. HYPERTENSION

UNKNOWN

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D50454

29d. Date signed (Month, Day, Year)

SEPTEMBER 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARASTOO YAZDANI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

State
Registrar

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN: MORRIS, CHARLES K

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

from 4 pages

269 S 8 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32461

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) IVAN JAY MAST				2. Date of Death Month Day Year OCTOBER 6, 2000		3. Time of Death 19:00 PM	
	4a. Facility Name (If not institution, give street and number) SANDTOWN BRIDGE AND ROUTE 287				4b. City, Town, or Location of Death GOLDSBORO		4c. County of Death CAROLINE	
Funeral Director	5. Social Security Number 221-74-4028		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 14 Yrs.		8. Date of Birth (Month, Day, Year) Dec 20, 1985	
	9. Birthplace (State or Foreign Country) Wyoming, DE.		10a. State DE.		10b. County KENT		10c. City, Town or Location Wyoming	
10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 64 APPLEGROVE SCHOOL ROAD		10f. Zip Code 19934		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farm worker		16b. Kind of Business/Industry Agriculture				
17. Father's Name (First, Middle, Last) Henry E. MAST				18. Mother's Name (First, Middle, Maiden Surname) Rosa J. Hershberger				
19a. Informant's Name/Relationship (Type, Print) Henry MAST				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 64 Applegrove School Rd, Wyoming, De 19934				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Amish Cemetery		20c. Date 10/10/00		20d. Location - City or Town, State Dover, Delaware		
21. Signature of Funeral Service Licensee William Greffaluk				22. Name and Address of Facility 61 S. Bradford Street Torbert Funeral Chapel, Dover, De 19904				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MULTIPLE INJURIES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
						24a. Was an autopsy performed? 1 Yes 2 No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE						
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Year) 10/6/00		28b. Time of Injury 530 PM		28c. Injury at Work? 1 Yes 2 No		
		28d. Describe how injury occurred PASSENGER OF PICKUP TRUCK INVOLVED IN COLLISION WITH TRACTOR TRAILER		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28f. Location (Street and Number or Rural Route Number, City or Town, State) ROUTE 287, AT SANDTOWN BRIDGE, GOLDSBORO, MD		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier NARY G. RIPLE, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 7, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 11 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32462

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JESSE NORRIS				2. Date of Death Month Day Year SEPTEMBER 27 2000		3. Time of Death 9:30AM														
	4a. Facility Name (If not institution, give street and number) DEVLIN MANOR NURSING HOME				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY														
Funeral Director	5. Social Security Number 705-09-3448		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) OCTOBER 11 1910														
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND														
Usual Residence of Decedent																					
10a. State MARYLAND			10b. County ALLEGANY			10c. City, Town or Location CUMBERLAND															
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number 12513 BEDFORD ROAD N.E.			10f. Zip Code 21502															
10g. Citizen of What Country? U.S.A.			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:															
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)															
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CAR INSPECTOR-RAILROAD			16b. Kind of Business/Industry B&O RAILROAD			17. Father's Name (First, Middle, Last) GEORGE W. NORRIS															
18. Mother's Name (First, Middle, Maiden Surname) HARRIETT E. APPLE			19a. Informant's Name/Relationship (Type, Print) EDWARD J. NORRIS SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10316 Birchwood Lane Waynesboro, PA 17268															
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sunset Memorial Park			20c. Date Oct. 1, 2000															
20d. Location - City or Town, State Cumberland, MD			21. Signature of Funeral Service Licensee 			22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>ACUTE RESPIRATORY FAILURE Due to (or as a consequence of):</td> <td>1 DAY</td> </tr> <tr> <td>b.</td> <td>ASPIRATION SYNDROME Due to (or as a consequence of):</td> <td>3 DAYS</td> </tr> <tr> <td>c.</td> <td>CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):</td> <td>6 MONTHS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	ACUTE RESPIRATORY FAILURE Due to (or as a consequence of):	1 DAY	b.	ASPIRATION SYNDROME Due to (or as a consequence of):	3 DAYS	c.	CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):	6 MONTHS	d.		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	ACUTE RESPIRATORY FAILURE Due to (or as a consequence of):	1 DAY																		
	b.	ASPIRATION SYNDROME Due to (or as a consequence of):	3 DAYS																		
	c.	CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):	6 MONTHS																		
	d.																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																		
28f. Location (Street and Number or Rural Route Number, City or Town, State)																					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier  MD			29c. License number D 23334			29d. Date signed (Month, Day, Year) SEPTEMBER 27, 2000															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR DINESH B. SHAH 625 KENT AVENUE CUMBERLAND MARYLAND 21502																					
31. Date filed (Month, Day, Year) SEP 29 2000			32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

MS

State
Registrar

Jan 2 1942

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32463

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES WESLEY OWENS

2. Date of Death

Month Day Year
9-30-2000

3. Time of Death

0135 a.m.

4a. Facility Name (If not institution, give street and number)

Allegany County Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

214 07 5350

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
6-19-1908

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

PA

10b. County

Bedford

10c. City, Town or Location

Hyndman

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

142 Water Street

10f. Zip Code

15545

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Lewis Wesley Owens

18. Mother's Name (First, Middle, Maiden Surname)

Susan (mnu) Hotchkiss

19a. Informant's Name/Relationship (Type, Print)

Patricia Hooker, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

46 Downs Road, Airville, PA 17302

20a. Method of Disposition

☒ Burial ☐ Cremation ☒ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hyndman Cemetery

Data

10-4-2000

20c. Location - City or Town, State

Hyndman, PA

21. Signature of Funeral Service Licensee

Harvey H. Zeigler

22. Name and Address of Facility

Harvey H. Zeigler Funeral Home
Hyndman, PA 15545

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.

Immediate Cause (Final disease or condition resulting in death)

a. ADENOCARCINOMA, LUNG

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONE YR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robustiano J. Barera Jr

29c. License number

D-14865

29d. Date signed (Month, Day, Year)

OCT. 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBUSTIANO J. BARERA, JR

Cumberland, MD 21502

Memorial Hospital Medical Building

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

Benita B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be dated for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Faint signature or name at the bottom center of the page.]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32464

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOIS JEAN STERNER PLATT				2. Date of Death Month SEPTEMBER Day 25 Year 2000		3. Time of Death 9:56 AM	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 213-40-4035	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 6, 1942		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number FURNACE STREET EXTN.				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME		
17. Father's Name (First, Middle, Last) ELMER ADAM ABE				18. Mother's Name (First, Middle, Maiden Surname) HAZEL RUTH O'BRIEN				
19a. Informant's Name/Relationship (Type, Print) KIMBERLY LONG / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 LAKEVIEW LODGE ROAD, LEESVILLE, LA 71446				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) RESILAWN MEMORIAL GARDENS		Date 9/29/2000		20c. Location - City or Town, State LAVALE, MARYLAND		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Urosepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 2 days								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic Ketoacidosis, Coronary Artery Disease, Acute Conjunctive Heart Failure, Upper Gastrointestinal Bleeding						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D0014865		29d. Date signed (Month, Day, Year) SEPTEMBER 25, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBUSTIANO J. BARRERA, MEMORIAL MEDICAL BLDG., 500 MEMORIAL AVE., CUMBERLAND, MD								
31. Date filed (Month, Day, Year) SEP 28 2000				32. Registrar's Signature 				

ORIGINAL

David C. Smith 1975 11/14/75

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

FREDERICK R. PEDDICORD
amend item 23a,27 per me G790 12/7/00 yf

Certificate of Death

Reg. No.

00 32465

Physician /Medical Examiner		FREDERICK R. PEDDICORD		2. Date of Death Month OCT. Day 7 Year 2000		3. Time of Death 2040 PM	
Funeral Director		4a. Facility Name (If not institution, give street and number) HOWARD COUNTY HOSPITAL		4b. City, Town, or Location of Death COLUMBIA		4c. County of Death HOWARD	
		5. Social Security Number 217 16 7372		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.	
				8. Date of Birth (Month, Day, Year) March 14, 1922		9. Birthplace (State or Foreign Country) Maryland	
		Usual Residence of Decedent					
		10e. State Maryland		10b. County Howard		10c. City, Town or Location Ellicott City	
						10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		10e. Street and Number 4005 St. John's Lane		10f. Zip Code 21042		10g. Citizen of What Country? United States	
		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1942-68		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
						14. Race - American Indian, Black, White, etc. white	
		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Staff Sergeant		16b. Kind of Business/Industry Army	
		17. Father's Name (First, Middle, Last) R.J. Brent Peddicord		18. Mother's Name (First, Middle, Maiden Surname) Helen E. Carr			
		19a. Informant's Name/Relationship (Type, Print) Allen B. Peddicord/Brother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4001 High Point Road Ellicott City, MD 21042			
		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Good Shepherd Cemetery		20c. Location - City or Town, State 10-12-2000 Ellicott City, MD	
		21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043			
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death	
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) M		28b. Time of Injury M	
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
		29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCT. 8, 2000	
		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARY G. RIPPLE, M.D.		111 Penn Street, Baltimore, Maryland 21201			
		31. Date filed (Month, Day, Year) OCT 11 2000		32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32466

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

EMMA BOWIE PICKETT

2. Date of Death

Month

Day

Year

3. Time of Death

SEP

24

2000

12:05 A.M.

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

215-30-4514

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

DEC. 6 1931

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND ANNE ARUNDEL

10b. County

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

28 SOUTH STREET

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATOR

16b. Kind of Business/Industry

C&P TELEPHONE CO.

17. Father's Name (First, Middle, Last)

JOHN HENDERSON

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE JONES

19a. Informant's Name/Relationship (Type, Print)

DANA JOHNSON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 SOUTH ST. ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN

Date

10/2/00

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

Harry D. Lane 1400482

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michelle Perello

29c. License number

CA 20-A-7245

29d. Date signed (Month, Day, Year)

25 SEP 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHELLE PERELLO LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER

BETHESDA, MD 20839-5600

31. Date filed (Month, Day, Year)

SEP 28 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

511

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Viola Etta Rudy		2. Date of Death Month Day Year September 27 2000		3. Time of Death 3:00 am	
4a. Facility Name (If not institution, give street and number) Thompson Group Home		4b. City, Town, or Location of Death Keedysville		4c. County of Death Washington	
5. Social Security Number 220-18-2149		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.	
8. Date of Birth (Month, Day, Year) April 5, 1925		9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent		10a. State Maryland		10b. County Washington	
10c. City, Town or Location Williamsport		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 16612 Bowers Farm Lane		10f. Zip Code 21795		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator	
16b. Kind of Business/Industry School Transportation		17. Father's Name (First, Middle, Last) Samuel Jacob Horning		18. Mother's Name (First, Middle, Maiden Surname) Violetta Velzora Young	
19a. Informant's Name/Relationship (Type, Print) Lois Rudy - Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Salem Avenue Hagerstown, Maryland 21740			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenlawn Memorial Park		20c. Location - City or Town, State Williamsport, Maryland	
20d. Date 9-29-00		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DEHYDRATION ALZHEIMER'S DISEASE		Approximate Interval Between Onset and Death 1 DAY 5 YEARS			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Group home			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Matthew G. Beckwith MD		29c. License number D53634	
29d. Date signed (Month, Day, Year) 9-27-00		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MATTHEW G. BECKWITH MD		11110 MEDICAL CAMPUS RD HAGERSTOWN MD 21742	
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32468

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edwin Joseph Rice				2. Date of Death Month October Day 1 Year 2000		3. Time of Death 12:10 pm	
	4a. Facility Name (If not institution, give street and number) Devlin Manor Nursing Home				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 219-07-4492		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 4, 1919	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Allegany		10c. City, Town or Location Cumberland	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 455 Walnut Street		10f. Zip Code 21502		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor		16b. Kind of Business/Industry Telephone Co.				
17. Father's Name (First, Middle, Last) Joseph Augustus Rice				18. Mother's Name (First, Middle, Maiden Surname) Maude E. (Kauffman)				
19a. Informant's Name/Relationship (Type, Print) Hilda Rice				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 455 Walnut Street, Cumberland, MD 21502				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Lukes Lutheran Cem.		20c. Location - City or Town, State 10/4/00 Cumberland, MD 21502				
21. Signature of Funeral Service Licensee <i>William B. Kight</i>				22. Name and Address of Facility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Myocardial infarction</i> Due to (or as a consequence of): b. <i>Coronary heart disease</i> Due to (or as a consequence of): c. <i>Ischemic cardiomyopathy</i> Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>immediate</i> <i>weeks</i> <i>months</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypertension</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>William B. Kight</i>		29c. License number D0017501		29d. Date signed (Month, Day, Year) Oct. 2, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AST Bellin RD 922 N. 1st Hwy 620212, 12221502								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature <i>Bruce B. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

11

Handwritten signature or initials

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32469

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna Elizabeth SMITH						2. Date of Death Month Day Year September 29 2000		3. Time of Death 7:40pm																										
	4a. Facility Name (If not institution, give street and number) Reeders Memorial Home						4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington																										
Funeral Director	5. Social Security Number 216-22-9247		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 7, 1914		9. Birthplace (State or Foreign Country) Maryland																										
	Usual Residence of Decedent																																		
To Be Completed by Funeral Director	10a. State Maryland		10b. County Washington		10c. City, Town or Location Hagerstown				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																										
	10e. Street and Number 17527 Virginia Avenue				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.																												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white																											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0-6 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker			16b. Kind of Business/Industry her own home																											
	17. Father's Name (First, Middle, Last) John E. Dick						18. Mother's Name (First, Middle, Maiden Surname) Sarah Rowe																												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Wanda Head Daughter-In-Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17527 Virginia Avenue, Hagerstown, Maryland 21740																														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery		20c. Location - City or Town, State Hagerstown, Maryland		20d. Date Oct. 3, 2000																										
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740																														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																		
	23b. Approximate Interval Between Onset and Death																																		
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Respiratory Failure</td> <td>one week</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Pneumonia</td> <td>one week</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td>Aspiration</td> <td>unknown</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Stroke</td> <td>unknown</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Respiratory Failure	one week	Due to (or as a consequence of):			b.	Pneumonia	one week	Due to (or as a consequence of):			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Aspiration	unknown	Due to (or as a consequence of):			d.	Stroke	unknown	Due to (or as a consequence of):		
Immediate Cause (Final disease or condition resulting in death)	a.	Respiratory Failure	one week																																
	Due to (or as a consequence of):																																		
	b.	Pneumonia	one week																																
	Due to (or as a consequence of):																																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Aspiration	unknown																																
	Due to (or as a consequence of):																																		
	d.	Stroke	unknown																																
	Due to (or as a consequence of):																																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D44996		29d. Date signed (Month, Day, Year) Sept. 30, 2000.																													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Zafar Malik 203 Lappans Rd. Boonsboro md 21713 301-4328470																																			
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 																																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32470

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES CRABLE SHRYOCK				2. Date of Death Month Day Year Sept. 30, 2000		3. Time of Death 10:30 a.m.	
	4a. Facility Name (If not institution, give street and number) 1114 KENTUCKY AVENUE				4b. City, Town, or Location of Death CUMBERLAND		4c. County of Death ALLEGANY	
Funeral Director	5. Social Security Number 217-10-4084		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 yrs.		8. Date of Birth (Month, Day, Year) Jan 4, 1914	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Allegany		10c. City, Town or Location Cumberland	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 1114 Kentucky Avenue		10f. Zip Code 21502		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Painter		16b. Kind of Business/Industry University			
	17. Father's Name (First, Middle, Last) William C. Shryock				18. Mother's Name (First, Middle, Maiden Surname) Lorena (Twigg)			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nellie E. Shryock				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Kentucky Avenue; Cumberland, MD 21502			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cem 2000 Flintstone, MD		Date 10/03		20c. Location - City or Town, State	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Nicholas J. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home P.A. Cumberland, Maryland 21502			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stroke Due to (or as a consequence of): b. Cerebrovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 hr year
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HBP, DM, Atherosclerosis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier Anthony Bollino M.D.	
To Be Completed by Physician/Medical Examiner	29c. License number D17565						29d. Date signed (Month, Day, Year) Oct 2, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anthony Bollino M.D. 922 National Highway LaVale MD 21502							
State Registrar	31. Date filed (Month, Day, Year) OCT 03 2000				32. Registrar's Signature Benita B Sparks			

Handwritten signature or initials.

100 8 9 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32471

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Melvin L. Snyder				2. Date of Death Month Day Year OCTOBER 01 2000		3. Time of Death 13:01	
	4a. Facility Name (If not institution, give street and number) Memorial Hospital & Medical Center				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
Funeral Director	5. Social Security Number 236-28-2005		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) May 25, 1923	
	9. Birthplace (State or Foreign Country) WV		10a. State WV		10b. County Mineral		10c. City, Town or Location Ridgeley	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number P.O. Box 622		10f. Zip Code 26753		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Distributor		16b. Kind of Business/Industry Distributing Co				
17. Father's Name (First, Middle, Last) Harry M. Snyder				18. Mother's Name (First, Middle, Maiden Summa) Emma (Watson)				
19a. Informant's Name/Relationship (Type, Print) Dorothy Snyder wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 622; Ridgeley WV 26753				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Restlawn Memorial Gard		Date 10/04		20c. Location - City or Town, State LaVale, MD		
21. Signature of Funeral Service Licensee Nicholas J. Scarpelli				22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 minute 20 Years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 Yes <input checked="" type="checkbox"/> 2 No <input type="checkbox"/> 3 Probably <input type="checkbox"/> 4 Unknown <input type="checkbox"/>		
						24a. Was an autopsy performed? 1 Yes <input type="checkbox"/> 2 No <input checked="" type="checkbox"/>		
						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>		
25. Was case referred to medical examiner? 1 Yes <input type="checkbox"/> 2 No <input checked="" type="checkbox"/>		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 Natural <input checked="" type="checkbox"/> 2 Accident <input type="checkbox"/> 3 Suicide <input type="checkbox"/> 4 Homicide <input type="checkbox"/> 5 Pending investigation <input type="checkbox"/> 6 Could not be determined <input type="checkbox"/>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes <input type="checkbox"/> 2 No <input type="checkbox"/>		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William D. Lamm		29c. License number D25406		29d. Date signed (Month, Day, Year) OCTOBER 2, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William D. Lamm 47 Virginia Avenue Cumberland, MD 21502								
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature Benjamin B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

0001 3 32473

Handwritten signature or mark

0001 3 0 730

00 32472

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

James P. Moore

OCT 02 2008

Certificate of Death

Reg. No.

00-32473

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Garnett R Sautter</u>				2. Date of Death Month <u>August</u> Day <u>3</u> Year <u>2000</u>		3. Time of Death <u>06:47</u>				
	4a. Facility Name (If not institution, give street and number) <u>Veteran's Hospital - Baltimore</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death				
Funeral Director	5. Social Security Number <u>579-48-9843</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>68</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>May 3, 1932</u>		9. Birthplace (State or Foreign Country) <u>Virginia</u>		
	Usual Residence of Decedent				10f. Zip Code <u>21804</u>		10g. Citizen of What Country? <u>USA</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. State <u>Maryland</u>		10b. County <u>Wicomico</u>		10c. City, Town or Location <u>Salisbury</u>							
10e. Street and Number <u>1021 Cecil Street</u>											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>Korea</u> If Yes, Give Year or Dates: <u>Air Force</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Auto Mechanic</u>				16b. Kind of Business/Industry <u>Sears Roebuck & Co.</u>			
17. Father's Name (First, Middle, Last) <u>Garnett Reese Sautter, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Mary Lillian Whitman</u>							
19a. Informant's Name/Relationship (Type, Print) <u>Bryan A. Sautter /Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>601 Barnsdale Dr., Salisbury, Md 21804</u>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Maryland Veterans Cem.</u>		Date <u>8/9/2000</u>		20c. Location - City or Town, State <u>Hurlock, Md</u>			
21. Signature of Funeral Service Licensee ▶ <u>David H. Thompson per DVR</u>				22. Name and Address of Facility <u>Holloway Funeral Home Professional Association 501 Snow Hill Road Salisbury, MD 21804</u>							
Physician /Medical Examiner	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Abdominal aortic aneurysm</u> Due to (or as a consequence of):							Approximate Interval Between Onset and Death			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>[Signature] MD</u>				29c. License number <u>P12446</u>		29d. Date signed (Month, Day, Year) <u>August 3, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>T Mattingly 22 South Greene St Baltimore, MD 21202</u>											
31. Date filed (Month, Day, Year) <u>SEP 22 2000</u>				32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32474

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Alexa Sherer

2. Date of Death

Month 09 Day 26 Year 2000

3. Time of Death

0400

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Spa Creek Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

315 34 4398

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 10 Day 13 Year 06

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1877 Severn Grove Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Legal Industry

17. Father's Name (First, Middle, Last)

Richard Gallagher

18. Mother's Name (First, Middle, Maiden Surname)

Mary Edna Peggs

19a. Informant's Name/Relationship (Type, Print)

Maureen Sherer/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1877 Severn Grove Road, Annapolis MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

9/22/00

20c. Location - City or Town, State

Alexandria VA

21. Signature of Funeral Service Licensee

Michael M. Hagon

22. Name and Address of Facility

Advent Funeral & Cremation Services

Annapolis MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute myocardial infarction*
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. J. J. Hagon

29c. License number

032056

29d. Date signed (Month, Day, Year)

9/29/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gay S. Sproue 2102 N. Washington Drive Chantilly, VA 20151

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

J. J. Hagon

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1000

25 2 500

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32475

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard John Schreiber Sr.				2. Date of Death Month Day Year OCT 03 2000		3. Time of Death 1710	
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 221-24-8828		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 74		8. Date of Birth (Month, Day, Year) April 1, 1926	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County Caroline		10c. City, Town or Location Greensboro	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 27391 Whitleysburg Road		10f. Zip Code 21639		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farmer		16b. Kind of Business/Industry agriculture		17. Father's Name (First, Middle, Last) George Schreiber	
	18. Mother's Name (First, Middle, Maiden Surname) Pearl Webber		19a. Informant's Name/Relationship (Type, Print) Anne Schreiber spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27391 Whitleysburg Rd Greensboro, Maryland 21639		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Greensboro Cemetery		20c. Location - City or Town, State Greensboro, Maryland		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute respiratory failure Due to (or as a consequence of): b. pneumonia Due to (or as a consequence of): c. severe chronic obstructive pulmonary disease years Due to (or as a consequence of): d. multifocal atrial tachycardia & hypotension 2 weeks		Approximate Interval Between Onset and Death 2 weeks 2 weeks		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 		29c. License number 046020		29d. Date signed (Month, Day, Year) 10/3/00.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Syed Ali 506 Idlewild Ave Easton, Maryland 21601	
	31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature 		33. Registrar's Title Registrar		34. Registrar's Office Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

9/22/2000/#1 WCHD/MAP

Certificate of Death

Reg. No.

00 32476

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRED H. Tolbert		2. Date of Death Month Day Year September 19, 2000		3. Time of Death 8:03 a.m.
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A
Funeral Director	5. Social Security Number 227-40-7954	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Jan. 26, 1934		9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Virginia		10b. County Accomack
	10c. City, Town or Location Chincoteague		10d. Inside City Limits 1 Yes 2 No		
	10a. Street and Number 4020 Main Street		10f. Zip Code 23336		10g. Citizen of What Country? U. S. A.
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Contractor		16b. Kind of Business/Industry Tolbert Corp.
	17. Father's Name (First, Middle, Last) Frank Tolbert		18. Mother's Name (First, Middle, Maiden Surname) Mary Hopkins		
	19a. Informant's Name/Relationship (Type, Print) Ruth M. Tolbert Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4020 Main Street, Chincoteague, Virginia 23336		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mechanics Cemetery		20c. Location - City or Town, State Chincoteague, Virginia
	21. Signature of Funeral Service Licensee Constance Salyer Bailey		22. Name and Address of Facility (Give kind of work done during most of working life. DO NOT use retired) Salyer Funeral Home Chincoteague, Virginia 23336		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Airway Obstruction Due to (or as a consequence of): b. Metastatic Squamous Cell Carcinoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 12 hours 6 months				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
24a. Was an autopsy performed? 1 Yes 2 No		24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier John J. Friedewald MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) September 19, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John J. Friedewald, MD Johns Hopkins Hospital, 600 North Wolfe St, Baltimore, MD 21289					
State Registrar	31. Date filed (Month, Day, Year) SEP 21 2000		32. Registrar's Signature Geneva B. Sparks		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32477

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES THEODORE TRIANTIS

2. Date of Death

Sept 28, 2006

3. Time of Death

8 AM

4a. Facility Name (If not institution, give street and number)

1550 Andover Lane

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

578-40-2737

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 19, 1930

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1550 Andover Lane

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Restaurant Equipment

17. Father's Name (First, Middle, Last)

Nich John Triantis

18. Mother's Name (First, Middle, Maiden Surname)

Evangelina Biacou

19a. Informant's Name/Relationship (Type, Print)

Paula K. Triantis (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1550 Andover Lane Frederick, Md. 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

Sept. 29, 2000

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

Dennis L. Davis

22. Name and Address of Facility

12525 Bradbury Ave.
Davis Funeral Home Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MYOCARDIAL ISCHEMIA

Approximate Interval Between Onset and Death

hours

a. Due to (or as a consequence of):

metastatic Prostat Carcinoma

years

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

HEGAZI, MD

29c. License number

D44164

29d. Date signed (Month, Day, Year)

9-29-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amr Zakaria Hegazi MD 801 TOLL HOUSE Avenue, Frederick MD 21701

State
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Benjamin B Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

James Triantis, Sept 28, 2006
Baltimore, Maryland 21215-0020 8:00 AM

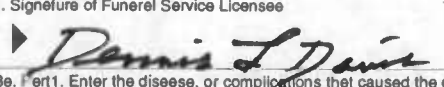
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32478

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY ETHEL WELCH						2. Date of Death Month Day Year Sept. 24, 2000		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) St. Catherine's Nursing Center						4b. City, Town, or Location of Death Emmitsburg		4c. County of Death Frederick County	
Funeral Director	5. Social Security Number 214-52-2944		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 99 Yrs.		8. Date of Birth (Month, Day, Year) 08-08-01		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Pa.		10b. County Adams County		10c. City, Town or Location Fairfield				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 171 McCleaf Lane				10f. Zip Code 17320			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Domestic			
17. Father's Name (First, Middle, Last) Hugh J. Crawley						18. Mother's Name (First, Middle, Maiden Surname) Ethel Arminger				
19a. Informant's Name/Relationship (Type, Print) Michael C. Welch, son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 171 McCleaf Lane Fairfield, Pa. 17320				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		Date 9-27-00		20c. Location - City or Town, State Fairfield, Pa.		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Avenue Smithsburg, Maryland				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Ischemic Cardiomyopathy 2 yrs Due to (or as a consequence of): b. Coronary Artery Disease 10 yrs Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive lung Disease Senile Dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number D18705		29d. Date signed (Month, Day, Year) 9. 25. 00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alan Carroll, MD s. Seton Avenue Emmitsburg, Md. 21727										
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the paper is devoted to a study of the properties of the function $f(x)$ defined by the equation $f(x) = \int_0^x f(t) dt$. It is shown that $f(x)$ is a constant function, and its value is determined by the initial condition $f(0) = 1$.

2. In the second part, we consider the function $g(x)$ defined by the equation $g(x) = \int_0^x g(t) dt + x$. It is shown that $g(x)$ is a linear function, and its value is determined by the initial condition $g(0) = 0$.

3. The third part of the paper is devoted to a study of the properties of the function $h(x)$ defined by the equation $h(x) = \int_0^x h(t) dt + x^2$. It is shown that $h(x)$ is a quadratic function, and its value is determined by the initial condition $h(0) = 0$.

4. In the fourth part, we consider the function $k(x)$ defined by the equation $k(x) = \int_0^x k(t) dt + x^3$. It is shown that $k(x)$ is a cubic function, and its value is determined by the initial condition $k(0) = 0$.

5. The fifth part of the paper is devoted to a study of the properties of the function $l(x)$ defined by the equation $l(x) = \int_0^x l(t) dt + x^4$. It is shown that $l(x)$ is a quartic function, and its value is determined by the initial condition $l(0) = 0$.

6. In the sixth part, we consider the function $m(x)$ defined by the equation $m(x) = \int_0^x m(t) dt + x^5$. It is shown that $m(x)$ is a quintic function, and its value is determined by the initial condition $m(0) = 0$.

7. The seventh part of the paper is devoted to a study of the properties of the function $n(x)$ defined by the equation $n(x) = \int_0^x n(t) dt + x^6$. It is shown that $n(x)$ is a sextic function, and its value is determined by the initial condition $n(0) = 0$.

8. In the eighth part, we consider the function $o(x)$ defined by the equation $o(x) = \int_0^x o(t) dt + x^7$. It is shown that $o(x)$ is a septic function, and its value is determined by the initial condition $o(0) = 0$.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32479

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mariah Watkins		2. Date of Death Month: September Day: 21 Year: 2000		3. Time of Death 8:55A
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City
Funeral Director	5. Social Security Number 212-35-6417	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 8 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) NOV. 6 1991		9. Birthplace (State or Foreign Country) MARYLAND		
Usual Residence of Decedent					
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location EDGEWATER	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 140 TYDINGS DRIVE			10f. Zip Code 21037		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: BLACK					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 3rd College (1-4 or 5+): 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STUDENT		16b. Kind of Business/Industry SCHOOL	
17. Father's Name (First, Middle, Last) ISAIAH WATKINS			18. Mother's Name (First, Middle, Maiden Surname) ELYNOR COATES		
19a. Informant's Name/Relationship (Type, Print) ISAIAH WATKINS (FATHER)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 140 TYDINGS DR. EDGEWATER, MD. 21037		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS		20c. Location - City or Town, State 9/29/00 ANNAPOLIS, MD.	
21. Signature of Funeral Service Licensee Harry D. Reese M00482		22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> <p>a. Multiple organ failure weeks</p> <p>b. graft vs host disease and vasoocclusive disease 1-2 months</p> <p>c. Bone marrow transplant 2 months</p> <p>d. T cell Acute lymphocytic leukemia and lymphoma 6 months</p>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Josephine Lok MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) September 21, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Josephine Lok MD Johns Hopkins Hospital, Baltimore, Maryland					
31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature [Signature]			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

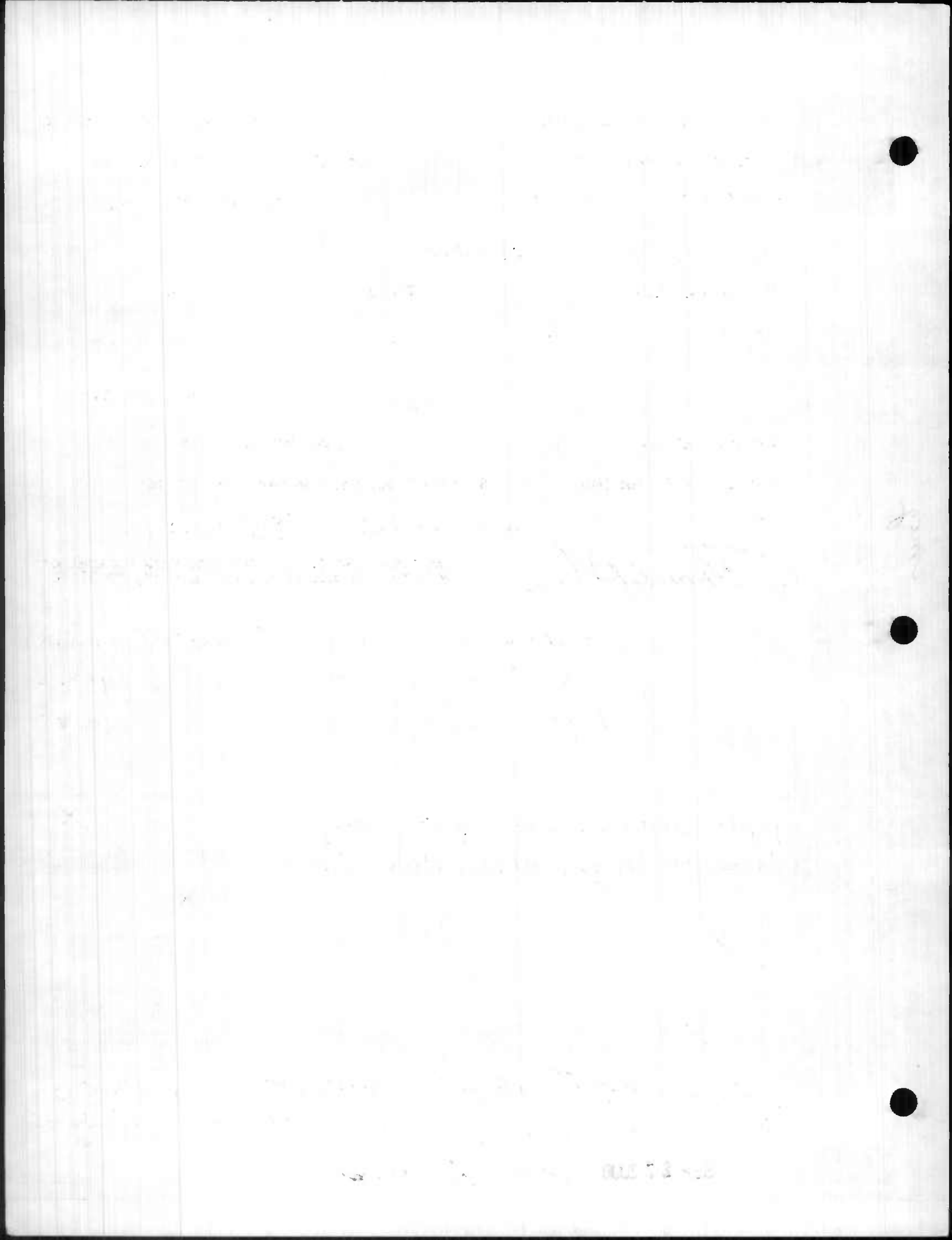
State of Maryland / Department of Health and Mental Hygiene

00 32480

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Witherbee Worthing				2. Date of Death Month Sept. Day 22, Year 2000				3. Time of Death 7:50 pm	
	4a. Facility Name (If not institution, give street and number) FutureCare-Chesapeake				4b. City, Town, or Location of Death Arnold				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 217-44-0255		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Sept 21, 1915		9. Birthplace (State or Foreign Country) Ohio	
	Usual Residence of Decedent				10a. State MD		10b. County Montgomery		10c. City, Town or Location Chevy Chase	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 3703 Leland Street				10f. Zip Code 20815	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemist				16b. Kind of Business/Industry Geological Survey				17. Father's Name (First, Middle, Last) Archie Worthing	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Experience Witherbee				19a. Informant's Name/Relationship (Type, Print) Robert Worthing/Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Linda Lane, Severna Park, MD 21146	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Park Lawn Memorial Park				20c. Location - City or Town, State Rockville, MD	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. cerebrovascular accident, recurrent Due to (or as a consequence of): b. atrial fibrillation Due to (or as a consequence of): c. hypertension Due to (or as a consequence of): d. Approximate Interval Between Onset and Death minutes years years	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number D41955	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 9-23-00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Elton MD 479 Jumpers Hole Rd #304 Severna Park MD 21146				31. Data filed (Month, Day, Year) SEP 27 2000	
	32. Registrar's Signature 				33. State Registrar SEP 27 2000				34. State Registrar SEP 27 2000	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended 10/10/00 10:55 Certificate of Death per FH Reg. No. 00 32481

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Ann Warren

2. Date of Death

Month Day Year
OCTOBER 6, 2000

3. Time of Death

19:00 PM

4a. Facility Name (If not institution, give street and number)

SANDTOWN BRIDGE AND ROUTE 287

4b. City, Town, or Location of Death

GOLDSBORO

4c. County of Death

CAROLINE

Funeral
Director

5. Social Security Number

221-20-2242

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
1-15-1933

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

DE

10b. County

Kent

10c. City, Town or Location

Felton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8283 Turkey Point Road

10f. Zip Code

19934 19943

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
116a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Zora B. Tatman

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Moore

19a. Informant's Name/Relationship (Type, Print)

Gooden Warren--husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 85 Woodside, DE 19980

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Odd Fellows Cemetery 10-11-00

Date

20c. Location - City or Town, State

Camden, DE

21. Signature of Funeral Service Licensee

John A. Prince

22. Name and Address of Facility

Pippin Funeral Home 19934
119 W. Camden-Wyoming Ave., Wyoming, DE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. MULTIPLE INJURIES
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☒ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)
10/6/0028b. Time of
Injury
530 P M28c. Injury at
Work?
1 ☐ Yes 2 ☒ No28d. Describe how injury occurred
DRIVER OF
PICKUP TRUCK INVOLVED IN
COLLISION WITH TRACTOR TRAILER
28f. Location (Street and Number or Rural Route Number,
City or Town, State) RT 287 AT SANDTOWN
BRIDGE, GOLDSBORO, MD29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mary G. Ripple, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

OCTOBER 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

OCT 10 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

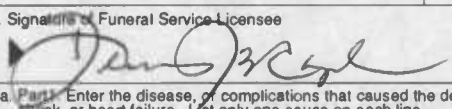
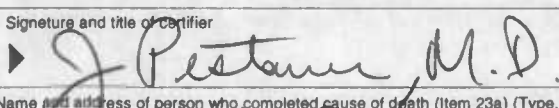

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 32482**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Damon Erik Adams				2. Date of Death Month Day Year OCTOBER 13, 2000		3. Time of Death 9:35 P.M.	
	4a. Facility Name (If not institution, give street and number) 2518 MOLTON WAY				4b. City, Town, or Location of Death WOODLAWN		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 219-02-0696		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 21 Yrs.		8. Date of Birth (Month, Day, Year) May 05, 1979	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 2412 Bibury Lane #303		10f. Zip Code 21244		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2yrs		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Warehouseman		16b. Kind of Business/Industry Freight Delivery				
17. Father's Name (First, Middle, Last) Daniel Adams Jr.				18. Mother's Name (First, Middle, Maiden Surname) Hope Scott				
19a. Informant's Name/Relationship (Type, Print) Hope Maddox (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Bibury Lane #303 Baltimore, Maryland 21244				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Druid Ridge Cemetery		Date 10/18/00		20c. Location - City or Town, State Pikesville, Maryland		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Cadle Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Gunshot Wound To Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOR <input type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 10/13/00		28b. Time of Injury (Hour, Minute) 9:21 PM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred Subject Shot		28f. Location (Street and Number or Rural Route Number, City or Town, State) House; 2518 Molton Way Woodlawn, Maryland				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  J. Pestaner, M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature 						

Handwritten signature

ADH
CLARENCE ALSTON, JR.
00-5813-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32483

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLARENCE T. ALSTON JR				2. Date of Death Month Day Year OCTOBER 11, 2000		3. Time of Death 1556 PM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-62-1625		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) 11-22-52	
	Usual Residence of Decedent		10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE	
10e. Street and Number 622 N. AUGUSTA AVENUE		10f. Zip Code 21229		10g. Citizen of What Country? USA		14. Race - American Indian, Black, White, etc. Specify: BLACK		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH GRADE College (1-4 or 5+) N/A		
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ADMINISTRATOR		16b. Kind of Business/Industry BALTIMORE CITY		17. Father's Name (First, Middle, Last) CLARENCE T. ALSTON SR		
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname) MAURICE CORNICK		19a. Informant's Name/Relationship (Type, Print) STANLEY ALSTON		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13806 DELANEY RD., WOODBRIDGE, VA 22193		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING MEMORIAL PARK		20c. Location - City or Town, State 10-16-00 RANDALSTOWN, MD		21. Signature of Funeral Service Licensee VAUGHN C. GREENE		
21. Signature of Funeral Service Licensee		22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALD. NATL PIKE, BALD. MD. 21229		23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Multiple Injuries		Approximate interval between Onset and Death		
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month/Day Year) 10/11/00		
28a. Date of Injury (Month/Day Year)		28b. Time of Injury 1510 M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Driver of Motor Vehicle Struck By another Vehicle		
28c. Injury at Work?		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Md.		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29a. Certifier (Check only one)		29b. Signature and title of certifier J. Rustan, M.D.		29c. License number OCME		29d. Date signed (Month, Day, Year) OCTOBER 12, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Rustan 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature [Signature]				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

INFORMANT G788 10-27-00 BR

AMEND ITEMS: #5, 10F, 19B, 20B, PER

Certificate of Death

Reg. No.

00 32484

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Damon Ansel Brown		2. Date of Death Month Day Year OCTOBER 14, 2000		3. Time of Death 02:43 A.M.
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS BAYVIEW		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 216-84-2852 216-84-2850	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 25 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Feb 02, 1975		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 4027 Ardley Avenue			10f. Zip Code 21213 21202		10g. Citizen of What Country? USA
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Landscaper		16b. Kind of Business/Industry State of Maryland	
17. Father's Name (First, Middle, Last) Aaron Henry Brown			18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Hicks		
19a. Informant's Name/Relationship (Type, Print) Mary E. Hicks (Mother)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4027 Ardley Avenue Baltimore, Maryland 21202 21213		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CEMETERY Baltimore Cemetery		20c. Location - City or Town, State 10/20/00 Baltimore, MD	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Cable Funeral Service 5502 Wimmer Avenue Baltimore, Maryland 21215		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple gunshot wounds Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 10-14-2000		28b. Time of Injury unknown AM	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject was shot			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street/sidewalk				28f. Location (Street and Number or Rural Route Number, City or Town, State) 5400 Force Road Baltimore City, Maryland	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Stephen S. Radentz, M.D.			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 14, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

perma. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 302.5.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM:31 PER C.V.R. G788 10-16-00 WR. State of Maryland / Department of Health and Mental Hygiene 00 32485
Certificate of Death Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Bertha G. Brown</u>				2. Date of Death Month <u>Oct.</u> Day <u>8</u> Year <u>2000</u>		3. Time of Death <u>5 P.M.</u>	
	4a. Facility Name (If not institution, give street and number) <u>6720 Long Hill Rd.</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>218-15-8585</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>87</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>April 23, 1913</u>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <u>W. Indies</u>		10. State <u>MD</u>		10b. County <u>Baltimore</u>	
To Be Completed by Funeral Director	10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Woodlawn</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <u>6720 Long Hill Rd.</u>		10f. Zip Code <u>21207</u>		10g. Citizen of What Country? <u>USA</u>			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6th</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Domestic</u>		16b. Kind of Business/Industry <u>Home</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>Edward Brown</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Emily Goode</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>UKlyn Bryant-daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6720 Long Hill Rd. Woodlawn, MD. 21207</u>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>King Memorial Park</u>		20c. Location - City or Town, State <u>10/14/00 Randallstown, MD.</u>			
	21. Signature of Funeral Service licensee <u>[Signature]</u>		22. Name and Address of Facility <u>Stary R March Funeral Home P.A. 6740 Fredhillen Pass Balto., MD. 21229</u>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Non Small Cell Lung CA</u> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <u>1 1/2 - 2 yrs</u>	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <u>Pulmonary Embolus</u> <u>Primary Hypertension</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <u>[Signature]</u>	
	29c. License number <u>D35069</u>						29d. Date signed (Month, Day, Year) <u>10-10-00</u>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Sandra Hairston, MD 3100 Wyman Park Drive Baltimore, MD</u>							
	31. Date filed (Month, Day, Year) <u>10-10-00</u>		32. Registrar's Signature <u>[Signature]</u>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32486

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) FRANCES BAKER					2. Date of Death Month Day Year OCT. 14 2000			3. Time of Death 5:10am	
	4a. Facility Name (If not institution, give street and number) ROLAND PARK PLACE					4b. City, Town, or Location of Death BALTIMORE			4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-46-1598		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 101 Yrs.		8. Date of Birth (Month, Day, Year) 05/05/1899		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent					10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. State MD		10b. County N/A		10e. Street and Number 830 WEST 40TH STREET		10f. Zip Code 21211		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4YRS College (1-4 or 5+) 4YRS				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE				16b. Kind of Business/Industry HOMEMAKER		
17. Father's Name (First, Middle, Last) RALPH ROBINSON					18. Mother's Name (First, Middle, Maiden Surname) ELLEN GOWEN					
19a. Informant's Name/Relationship (Type, Print) HENRY S. BAKER JR. (SON)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16916 WESLEY CHAPEL RD. MONKTON, MD. 21111.					
20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY			20c. Location - City or Town, State 10/16/2000 BALTO., MD.				
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Chronic Obstructive Lung Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 7 days 25 yrs										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCD										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 					29c. License number 12399		29d. Date signed (Month, Day, Year) OCTOBER 14, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES O. DONOVAN III M.D. 6565 N. CHARLES ST. TOWSON, MD. 21204.										
31. Date filed (Month, Day, Year) OCT 16 2000			32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32487

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Joan Brehm				2. Date of Death Month Day Year October 12 2000		3. Time of Death 2:09pm
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 212-34-5501	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 19, 1935	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Essex			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1503 Nicolay Way			10f. Zip Code 21221		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Thomas Wilson Davis				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Nellie Hood		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Husband) Mr. Clarence H. Brehm, Sr.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Nicolay Way Essex, Maryland 21221			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		Date 10/16/2000	20c. Location - City or Town, State Rossville, MD	
	21. Signature of Funeral Service Licensee Johnny L. Biss			22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage chronic obstructive pulmonary disease Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier DR Giuseppe Esposito, MD				29c. License number RD203265		29d. Date signed (Month, Day, Year) 10-12-00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR Giuseppe Esposito 9000 Franklin Square Drive Baltimore MD 21237							
State Registrar	31. Date filed (Month, Day, Year) OCT 16 2000			32. Registrar's Signature [Signature]			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32488

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles A. Beitzel				2. Date of Death Month Day Year OCTOBER 12, 2000		3. Time of Death 4:10 AM		
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE		4c. County of Death AA COUNTY		
Funeral Director	5. Social Security Number 212-30-0041	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 5, 1932		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Pasadena			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 8020 Cuba Drive				10f. Zip Code 21122		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1952-56		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance			16b. Kind of Business/Industry State of Maryland			
	17. Father's Name (First, Middle, Last) Earl Beitzel				18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Gray				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary A. Beitzel - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8020 Cuba Drive, Pasadena, MD 21122				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date Oct. 16		20c. Location - City or Town, State Baltimore, Maryland		
	21. Signature of Funeral Service licensee 		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D-40521		29d. Date signed (Month, Day, Year) October 13, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR MAHESH CHANEY 7845 Oakwood Road Suite 205 Glen Burnie, MD 21061									
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32489

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carl H. Barnes				2. Date of Death Month: October Day: 11 Year: 2000				3. Time of Death 8:50 AM		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 213-01-1992		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 27 1917		9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland				10b. County Anne Arundel		10c. City, Town or Location Pasadena		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 215 Mulberry Avenue				10f. Zip Code 21122		10g. Citizen of What Country? USA				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Carpentry-Self-employed				
	17. Father's Name (First, Middle, Last) Charles E. Barnes				18. Mother's Name (First, Middle, Maiden Surname) Mary M. Wachter						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Neibert E. Barnes - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 Carroll Road, Glen Burnie, MD 21060						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. Location - City or Town, State Oct. 13 Glen Burnie, Maryland						
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 week						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Coronary artery disease Chronic Obstructive pulmonary disease				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature] M.D.		29c. License number D 43977		29d. Date signed (Month, Day, Year) October 11 2000				
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyprien Ouesingbe, 301 Hospital Drive, Glen Burnie, MD 21061				31. Date filed (Month, Day, Year) OCT 16 2000				32. Registrar's Signature [Signature]		

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 32490**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHY BAIRD				2. Date of Death Month OCTOBER Day 11th Year 2000		3. Time of Death 10:15 AM	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 213-20-6445		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) February 26, 1920	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 617 St Dunstan's Road		10f. Zip Code 21212		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Elmer Rudolph Lanke				18. Mother's Name (First, Middle, Maiden Surname) Ethel Dorothy Pope			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Barbara B. Shaw DTR				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1506 Ivy Hill Road Cockeysville, Maryland 21030			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		20c. Location - City or Town, State 10-16-00 Lutherville Maryland		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Bennis Stephen Kenakis</i>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): ISCHEMIC BOWEL			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RECENT ACUTE MYOCARDIAL INFARCTION, ATRIAL FIBRILLATION, LEFT LEG ARTERIAL EMBOLI, HYPERTENSION, CONGESTIVE HEART FAILURE				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>MD</i>		29c. License number P12564	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) OCTOBER 11th 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELIZABETH THUY N. NGUYEN GOOD SAMARITAN HOSPITAL MD 21239		31. Date filed (Month, Day, Year) OCT 16 2000			
	32. Registrar's Signature <i>Bennis Stephen Kenakis</i>		33. Date of Death (Month, Day, Year) OCTOBER 11th 2000					

ORIGINAL

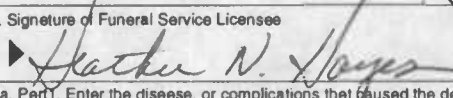
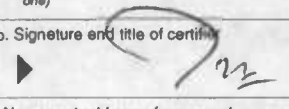

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32491

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM H. CARROLL				2. Date of Death Month Day Year OCTOBER 11, 2000		3. Time of Death 9:20 P.M.	
	4a. Facility Name (If not institution, give street and number) STELLA MARIS HOSPICE				4b. City, Town, or Location of Death TIMONIUM		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-05-6451	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/18/13		9. Birthplace (State or Foreign Country) VIRGINIA
	Usual Residence of Decedent							
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location LOCH RAVEN VILLAGE			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1709 EDGEWOOD ROAD				10f. Zip Code 21234		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) OFFICE PERSONNEL			16b. Kind of Business/Industry RAILROAD	
17. Father's Name (First, Middle, Last) WILLIAM CARROLL				18. Mother's Name (First, Middle, Maiden Surname) ELEANOR ELLIOTT				
19a. Informant's Name/Relationship (Type, Print) MARY A. CARROLL WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 EDGEWOOD RD. BALTIMORE, MD 21234				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY		20c. Location - City or Town, State 10/16/00 BALTIMORE, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Prostate Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D43725		29d. Date signed (Month, Day, Year) 10/13/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093								
31. Date filed (Month, Day, Year) OCT 16 2000				32. Registrar's Signature 				

October 11, 2000 9:20 p.m.

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

William Carroll

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32492

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Porter Crigger

2. Date of Death

Month
10Day
14Year
00

3. Time of Death

5:45 PM

4a. Facility Name (If not institution, give street and number)

Dennis Elderland Center Manor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

220-05-1667

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

July 3, 1915

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Lansdowne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

104 1/2 Ridge Ave.

10f. Zip Code

21227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Timothy Crigger

18. Mother's Name (First, Middle, Maiden Surname)

Ida Bridgeman

19e. Informant's Name/Relationship (Type, Print)

Arthur L. Drager / lawyer

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 N. Calvert St. Suite 620 Baltimore, MD. 21202

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

10-17-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Rd. Arbutus, MD. 21227

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

5 Years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sanjay P. Shah, MD

29c. License number

D0052940

29d. Date signed (Month, Day, Year)

OCT 14 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANJAY P. SHAH, MD 821 N. Euteraw #407, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Crigger, Robert

Mr. J. H. Johnson
Care of J. H. Johnson
3000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32493

AMEND ITEM: 7 PER F.H. G788 10-20-00 WR.
Amended Item# 10e,8 per F.H.G788 101/8/2000 EW

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Geraldine Chapman				2. Date of Death Month Day Year Oct. 11 2000		3. Time of Death 6:32 pm		
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City		
Funeral Director	5. Social Security Number 215-14-7812		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 1, 1912	9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
10a. State MD		10b. County NA		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1 W. CONWAY ST. APT. 104				10f. Zip Code 21201		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales person			16b. Kind of Business/Industry Jewelry Store		
17. Father's Name (First, Middle, Last) Samuel Mackall				18. Mother's Name (First, Middle, Maiden Surname) NANNIE BEAN					
19a. Informant's Name/Relationship (Type, Print) Gwendolyn Bracey				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 Edgewood Rd. Apt. 135 Balto Md 21215					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Park 10/16/00 Balto. Md.			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Home A. Thompson				22. Name and Address of Facility March Funeral Home West, Inc. 4300 Wabash Ave. Balto. Md. 21215					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier [Signature]				29c. License number P14678			29d. Date signed (Month, Day, Year) 10-11-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry J Mark 22 S. Greene St. Baltimore, MD 21201									
31. Date filed (Month, Day, Year) OCT 16 2000				32. Registrar's Signature [Signature]					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32494

Physician
(Medical
Examiner)

1. Decedent's Name (First, Middle, Last)

Catherine Cox

2. Date of Death

Month

Day

Year

OCTOBER 11, 2000

3. Time of Death

1600

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

215-16-1330

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 15 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4702 Henshaw Lane

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cashier

16b. Kind of Business/Industry

Retail Grocery

17. Father's Name (First, Middle, Last)

Mathew Muller

18. Mother's Name (First, Middle, Maiden Surname)

Christina Kauten

19a. Informant's Name/Relationship (Type, Print)

Frederick Cox (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

300 Kramer Rd., Pasadena, MD. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

Oct. 14

20c. Location - City or Town, State

2000 Glen Burnie, Maryland

21. Signature of Funeral Service Licensee

Michael Stallings

22. Name and Address of Facility

Stallings Funeral Home, P.A.

3111 Mountain Rd., Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

INTRACEREBRAL HEMORRHAGE

MINUTES

Due to (or as a consequence of):

HYPERTENSION

YEARS

Due to (or as a consequence of):

TYPE 2 DIABETES MELLITUS

YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

TOBACCO ABUSE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Benjamin Malkiel

29c. License number

H54409

29d. Date signed (Month, Day, Year)

OCTOBER 11, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

BENJAMIN MALKIEL HOSPITAL DRIVE GLEN BURNIE, MARYLAND

State
Registrar

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

Benjamin S. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Cox Catherine

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32495

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patricia H. Duncan		2. Date of Death Month Day Year OCTOBER 12 2000		3. Time of Death 9:50 A.M.						
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER		4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE						
Funeral Director	5. Social Security Number 214 36 6176	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.						
	8. Date of Birth (Month, Day, Year) May 28, 1939		9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent											
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex							
10e. Street and Number 8 Mingo Lane		10f. Zip Code 21221		10g. Citizen of What Country? USA							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper							
16b. Kind of Business/Industry Construction		17. Father's Name (First, Middle, Last) James Hutson		18. Mother's Name (First, Middle, Maiden Surname) Mary Mastercola							
19a. Informant's Name/Relationship (Type, Print) Robert Duncan (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Mingo Lane Baltimore, Md. 21221									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens Of Faith Cem. 10/16/2000		20c. Location - City or Town, State Baltimore, Md.							
21. Signature of Funeral Service Licensee John W. Burkhardt MO 1091		22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. LIVER FAILURE Due to (or as a consequence of):</td> <td rowspan="4">Approximate interval Between Onset and Death</td> </tr> <tr> <td>b. METASTASIS OF LIVER Due to (or as a consequence of):</td> </tr> <tr> <td>c. SMALL CELL LUNG CANCER Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LIVER FAILURE Due to (or as a consequence of):	Approximate interval Between Onset and Death	b. METASTASIS OF LIVER Due to (or as a consequence of):	c. SMALL CELL LUNG CANCER Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LIVER FAILURE Due to (or as a consequence of):	Approximate interval Between Onset and Death									
	b. METASTASIS OF LIVER Due to (or as a consequence of):										
	c. SMALL CELL LUNG CANCER Due to (or as a consequence of):										
	d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M							
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier J. H. H. H. H. H.		29c. License number D 191825		29d. Date signed (Month, Day, Year) 10/12/00							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITA MATHUR, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237											
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature [Signature]									

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 10c,e per fh G788 10/17/00
 Amended Items#10c,e,f perFHG788 10/16/2000 EW

Certificate of Death

Reg. No.

00 32496

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
 Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 23b show
 any injury or other traumatic event, the Medical Examiner must be notified at
 200-555-1234.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
 within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and
 completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) ROSE MARIE DRABISH		2. Date of Death Month Day Year Oct. 4, 2000		3. Time of Death 2:30AM	
4a. Facility Name (If not institution, give street and number) Ma Maison 9404 Belair Rd		4b. City, Town, or Location of Death Nottingham		4c. County of Death Baltimore	
5. Social Security Number 236-18-5391	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10/8/1912
9. Birthplace (State or Foreign Country) Canton, Ohio					
Usual Residence of Decedent					
10e. State MD	10b. County Baltimore	10c. City, Town or Location Kingsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number Ma Maison 9404 Belair RD 6 Blue Stone Court		10f. Zip Code 21236 21087		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 6 years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry Balto. County Board of Ed.	
17. Father's Name (First, Middle, Last) Lewis Detch		18. Mother's Name (First, Middle, Maiden Surname) Kristina (Unknown)			
19a. Informant's Name/Relationship (Type, Print) Linda Mattio (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Blue Stone Court Kingsville, MD 21087			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Creamtory		20c. Location - City or Town, State 10/7/00 Baltimore, Maryland	
21. Signature of Funeral Service Licensee <i>E.F. Lassahn</i>		22. Name and Address of Facility E.F. Lassahn Funeral Home 11750 Belair Rd Kingsville, MD 21087			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. stroke Due to (or as a consequence of): b. dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Samuel C. Durso MD		29c. License number D47040		29d. Date signed (Month, Day, Year) 10/4/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel C. Durso MD 4924 Campbell Blvd Suite 201 Baltimore MD 21236					
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature <i>Sparks</i>			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32497

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry Earnest DiNicola, Jr.				2. Date of Death Month Day Year October 15, 2000		3. Time of Death 3:03 pm	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 211-20-6239	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 26, 1931		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 323 Southeastern Terrace				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1951-1954		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Agent			16b. Kind of Business/Industry Insurance Company	
17. Father's Name (First, Middle, Last) Henry DiNicola				18. Mother's Name (First, Middle, Maiden Surname) Antionetta Gatta				
19a. Informant's Name/Relationship (Type, Print) Josephine R. DiNicola (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 323 Southeastern Terrace, Essex, Maryland 21221				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens		Date 10/18/2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee				22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e. Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 1 day
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier S. Shivananda MD				29c. License number D 52379		29d. Date signed (Month, Day, Year) 10/16/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SAVITHA SHIVANANDA 1124 mae Avenue Baltimore MD 21221								
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32498

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JAMES R. ENGLISH

2. Date of Death

OCTOBER 9, 2000

3. Time of Death

11:49pm

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

5. Social Security Number

218-42-2897

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAY 2, 1948

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3905 FAIRVIEW AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRICAN
AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER/HANDYMAN

16b. Kind of Business/Industry

PAINT

17. Father's Name (First, Middle, Last)

HALLIE ENGLISH

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE WILLIAMS

19a. Informant's Name/Relationship (Type, Print)

FANNIE WILLIAMS MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3905 FAIRVIEW AVE. BALTIMORE, MD 21216

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Date

10/14/00

20c. Location - City or Town, State

LANDSDOWNE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GILMORE STREET, BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN

DM

RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient

26. Place of Death (Check only one)

☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46250

29d. Date signed (Month, Day, Year)

10/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

922 W North Ave Baltimore, MD 21217

State
Registrar

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32499

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIS D FISHER		2. Date of Death Month October Day 13 Year 2000		3. Time of Death 12:45AM
	4a. Facility Name (If not institution, give street and number) Baltimore Rehabilitation and Extended Care		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 220-03-3927	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Aug 02, 1920		9. Birthplace (State or Foreign Country) Virginia		
To Be Completed by Funeral Director	10a. State MD	10b. County Baltimore	10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 3406 Keston Road		10f. Zip Code 21207		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 10/16/43 04/11/46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crain Operator		16b. Kind of Business/Industry Steel
	17. Father's Name (First, Middle, Last) Sam Fisher		18. Mother's Name (First, Middle, Maiden Surname) Mamie Fisher		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Alberta Fisher (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Keston Road Baltimore, Maryland 21207		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet Cem		20c. Location - City or Town, State 10/19/00 Owings Mills, MD.
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 7 years				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus				
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D0032548		29d. Date signed (Month, Day, Year) October 13, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PERRY L Colvin 10 North Greene Street Baltimore, Maryland					
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32500

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

MARGARET ELEANOR WHITELEY FOSTER

2. Date of Death

OCT 14 2000

3. Time of Death

5:00am

4a. Facility Name (If not institution, give street and number)

213 EDGEVALE RD.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

220-46-6637

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

03/01/1911

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

213 EDGEVALE RD.

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4YRS

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ARTIST

16b. Kind of Business/Industry

ARTIST

17. Father's Name (First, Middle, Last)

WILLIAM TALBOT WHITELEY

18. Mother's Name (First, Middle, Maiden Surname)

LOUISE E. EVANS

19a. Informant's Name/Relationship (Type, Print)

SALLY L. FOSTER (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 EDGEVALE RD. BALTO., MD. 21210.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

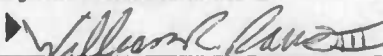
DRUID RIDGE CEM.

Data

10/17/2000 PIKESVILLE, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

HENRY W. JENKINS & SONS CO.
4905 YORK RD. BALTO., MD. 21212.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CORTICOSPINAL GANGLIONIC DEGENERATION 6 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

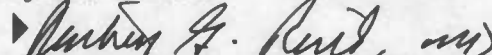
M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

037272

29d. Date signed (Month, Day, Year)

October, 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN G. REICH M.D. 601 N. CAROLINE ST. BALTO., MD. 21287.

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

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/Medical
Examiner

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